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ABSTRACT

This report summarizes the latest available statistics on international achievements in registering each child at birth; immunizing all children; assisting adolescents, particularly girls; and addressing homelessness in wealthy nations. Each of the report's sections contains a commentary, related statistics, and a discussion on progress and disparity in the section's particular area. Following a foreword by United Nations Secretary-General Kofi A. Annan, and an introduction by Carol Bellamy, executive director of UNICEF, the sections of the report are: (1) "Birth Registration: The 'First' Right" (Unity Dow); (2) "Immunization: Going the Extra Mile" (Ralph H. Henderson); (3) "Claiming the Future" (Geeta Rao Gupta), on meeting the needs of adolescents; and (4) "Hardship in the Midst of Plenty" (Philip Alston), on conditions of the homeless. (EV)

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THE PROGRESS OF NATIONS

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The nations of the world ranked according to their achievements in fulfilment of child rights and progress for women

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1998

THE PROGRESS OF NATIONS

The day will come
when nations will be judged
not by their military or economic strength,
nor by the splendour of their capital
cities and public buildings,
but by the well-being of their peoples:
by their levels of health, nutrition and education;
by their opportunities to earn a fair reward for their
labours; by their ability to participate in the
decisions that affect their lives; by the respect that is
shown for their civil and political liberties;
by the provision that is made for those who are
vulnerable and disadvantaged;
and by the protection that is afforded to the
growing minds and bodies of their children.
The Progress of Nations, published annually
by the United Nations Children's Fund, is
a contribution towards that day.

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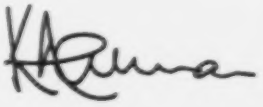
Foreword

The Progress of Nations is a clarion call for children. It asks every nation on earth to examine its progress towards the achievable goals set at the World Summit for Children in 1990 and to undertake an honest appraisal of where it has succeeded and where it is falling behind.

This year's report highlights successes attained and challenges remaining in efforts to register each child at birth, to immunize every child on earth and to help adolescents, particularly girls, as they set out on the path towards adulthood. With its clear league tables, *The Progress of Nations* is an objective scorecard on these issues. Commentaries by leading thinkers and doers stress the need for an approach to development based on child rights, calling on governments to fulfil the promises they made in ratifying the Convention on the Rights of the Child.

The Progress of Nations reminds us annually that rhetoric about children must be backed up with action. I would commend it to anyone concerned about the status of our most vulnerable citizens.



Kofi A. Annan
Secretary-General
United Nations

Introduction: Championing children's rights

Each year, *The Progress of Nations* ranks countries, not by the traditional yardstick of economic growth, but by the well-being of their children. One might expect the richest nations to be at the top of the class when it comes to providing for children. But the report confirms that monetary progress does not guarantee social development.

In fact, some of the most impoverished nations are making the greatest strides towards achieving the goals set at the 1990 World Summit for Children. Why? Because they have made fulfilling the basic needs of children a priority.

Charity is no longer enough. With only two holdouts preventing universal ratification of the Convention on the Rights of the Child, the community of nations is rapidly coming to grips with the fact that each and every child is entitled to a whole series of fundamental rights.

In recognition of that shift in thinking, *The Progress of Nations* is also expanding its focus. This year, for the first time, we look at children's civil rights, beginning at the beginning: with the right to be registered at birth. For millions of children, the lack of birth registration means exclusion from the rights and privileges a nation offers its citizens, such as education and health care.

This year's report also charts the dramatic progress in child immunization over the past 20 years, a legacy of which we can be proud. But the struggle is far from over: 2 million children still die each year because they lack access to this basic and inexpensive public health service.

The Progress of Nations 1998 points out that society has largely overlooked the vulnerabilities of adolescence in developing countries — and that young people, who make up one sixth of the people on earth, need the support of their elders if they are to fulfil their promise and avoid the inevitable perils that lie ahead.

In addition, this year's report outlines the growing shame of homelessness in the richest countries, where there is an ominous rise in the proportion of families and young people lacking permanent shelter.

The gains made on behalf of children in the past half-century were scarcely imaginable when the Universal Declaration of Human Rights was signed in 1948. As we celebrate the 50th anniversary of that historic document, we must rededicate ourselves to ensuring that the rights set out in the Declaration and the galaxy of human rights instruments that have flowed from it — including the Convention on the Rights of the Child — are fulfilled for every child.

Carol Bellamy
Executive Director
UNICEF

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Birth registration: The 'first' right

Unity Dow

A birth certificate is a ticket to citizenship. Without one, an individual does not officially exist and therefore lacks legal access to the privileges and protections of a nation. Civil registration is also the basic tool by which an efficient government counts its citizens and plans the schools, health centres and other services they need. Yet many nations lack effective systems for recording births. Every year, about 40 million babies — one third of all births — go unregistered around the world.

Hidden behind the well-known images of children who have missed out on life's opportunities for want of adequate care is a huge but silent group of children denied another fundamental right: the right to a name and nationality. These children are denied their birthright by their very invisibility. Lacking birth certificates, they spend their lives on the edges of the 'official' world, skirting or falling over obstacles that never arise in the paths of those who had the good fortune to be registered when they were born.

In the scheme of things, the need for a birth certificate may not seem profound, especially when compared with the hurdles children routinely have to scale in developing countries. But in reality, that piece of paper is crucial. It is the proof that what might be called the 'first' right, the right to an official identity, has been fulfilled.

Registration of birth is the State's first acknowledgement of a child's existence. It represents recognition of a child's significance to the country and of his or her status under the law. This ticket to citizenship opens the door to the fulfilment of rights and to the privileges and services that a nation offers its people.

Without proof of birth, a child cannot be legally vaccinated in at least 20 countries. More than 30 countries require birth registration before a child can be treated in a health centre. Most countries demand to see a birth certificate before enrolling a child in school. Many require one for supplemental feeding programmes. Such fundamental activities as getting married, opening a bank account, owning land, voting and obtaining a passport may be denied to a person without a birth certificate, because it is the basis on which a country identifies its citizens.

In addition to conferring privilege, proof of birth can also protect. With it, a boy can verify that he is ineligible for military service, a girl that she is too young to go to work. Registration can offer a degree of protection from sex traffickers. Knowing that a girl without papers is more vulnerable and less likely to run away, traffickers typically snare their victims in remote villages where poverty is high and registration rates are low.

And a birth certificate can be a useful ally in the hands of a teenager accused of a crime. I am presiding over a murder trial of a young man who doesn't have a birth certificate. If convicted, he could face the hangman's noose because he cannot prove that he was under 18 at the time the crime was committed.

If birth registration is significant for the individual, it is profound for the nation. Without vital registration systems capable of determining how many people live within a country's borders, the authorities may not know how many doses of vaccine to buy or how many schoolrooms to build. Without a registration system, a country does not know its own birth rate — or death rate. An effective system of birth registration is fundamental not only to the fulfilment of child rights but to the rational operation of a humane government in the modern world.

Millions are 'missing'

The number of people who have been denied the right to birth registration is unknown, and therein lies the problem. Many countries simply do not have adequate systems for keeping track. The available data suggest that many millions of citizens have slipped between the cracks — or, more accurately, the chasms — of government registries. Every year, around 40 million births go unregistered.

The right to be registered at birth is rooted in article 7 of the Convention on the Rights of the Child. It states: "The child shall be registered immediately after birth and shall have the right from birth to a name [and] the right to acquire a nationality. . . ." There is no equivocation here; the 191 countries that have ratified the Convention are obligated to fulfil this pledge.

And they are obligated to make clear to their citizens why it is important. In rural societies where people live their entire lives within a small radius, where

Unity Dow, recently appointed the first female High Court Judge in Botswana, has a long record as a human rights attorney. She founded the Women and Law in Southern Africa Research Project and is a member of International Women's Rights Watch, an advocacy organization. Judge Dow was the plaintiff in a ground-breaking legal case that overturned Botswana's nationality law and led to passage of legislation allowing women to pass on their nationality to their children. She has also written about the link between the Convention on the Rights of the Child and children's legal status in Botswana.

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the teacher is your neighbour and the health worker your aunt, the idea that you need a piece of paper to prove your existence may be unfathomable. And to suggest that children must be registered for purposes of government planning is in some cases plainly threatening.

But the world is changing, and the circles in which people spend their lives are enlarging. In this far more complex and anonymous environment, proving nationality is not a utopian exercise in child rights. It is a practical necessity. Whether migrating to the city for work or fleeing armed conflict across a national border, a person who lacks proof of identity is, in the eyes of officials, a non-person.

Governments need to make the process easier. Many hospitals now begin the registration process as soon as the baby is born, but that is only a partial solution. In some areas of the world, such as Africa and southern Asia in particular, more than half of all babies are delivered outside hospitals.

A country's birth registration system may fail, by accident or design, to function for all the people. Myanmar has three levels of citizenship: Since 1982, only people who can prove continuous residence and no intermarriage back to their great-grandfathers have been granted full citizenship. Until recently in Thailand, many children of the 750,000 hill tribe population were not eligible for nationality because their parents were not Thai citizens.

The obstacles to registration are often banal, the product of misplaced priorities and bureaucratic inadequacies. Poor and rural countries tend to have lower registration rates, struggling as they must to cope with the inevitable shortages of trained personnel and modern technology, the logistical problems of travelling to registry offices and ignorance or fear of the process. As a result, birth registration lags in countries such as Sierra Leone, which has a registration rate of less than 10 per cent; Zimbabwe, with around one third registered; and Bolivia, where about half the people have a birth certificate.

Yet other countries, though dealing with economic and other difficulties, still manage to register a significant proportion of their children. Despite per capita gross national product of less than $800 a year, eight countries — Armenia, Azerbaijan, China, Honduras, Kyrgyzstan, Mongolia, Sri Lanka and Tajikistan — manage to register at least 90 per cent of births.

Some countries have not managed even to establish a mandatory birth registration system, among them Afghanistan, Cambodia, Eritrea, Ethiopia, Namibia and Oman. Some of these countries may keep other forms of records — such as Oman, which records children in a national health register once they visit a health centre — but such procedures are prone to errors of both omission and commission. They cannot replace a dedicated birth registration system. The Palestinian Authority is in the process of developing such a system, transferring birth data from the records of the Israeli Government.

There are many specific reasons, some of them quite rational, why families avoid registering their children. Most commonly, they simply cannot overcome the logistical hurdles of getting to the proper office, and governments must take steps to solve this problem by decentralizing the registrars. Registration may also conflict with tradition, or ethnic minorities may view it as an official attempt to dilute their culture.

In Madagascar, where traditional naming practices are considered sacred, the civil registration system is not widely regarded as worthwhile. In Kenya, birth registration became compulsory for whites in 1904, but only in 1971 did it become mandatory for all. Viewing registration as a colonial custom unconnected to their culture, many citizens were slow to accept its benefits.

Ideally, babies born in hospitals are registered before they go home. Countries with high percentages of home births tend to have lower rates of registration because of the logistical obstacles families face.

A person who is knowingly skirting the law will certainly be reluctant to report vital events to the government. So it is no surprise that in China a main reason for non-registration at birth is nonconformance with the prescribed family planning policies.

Sometimes the system itself is an obstacle. This fundamental right costs money in at least 50 countries, which charge for either the registration or the certificate. Or the procedure may be clouded in bureaucratic confusion, as in Indonesia, where collection of birth information is complicated by the overlapping jurisdictions of government and civic bodies: the Ministries of Interior, Justice, Health and Family Welfare, as well as the Central Bureau of Statistics.

Parents in China have 30 days to register a child's birth, but they must do so in the village of the mother's official residence, a problem for families who migrate for work. This obstacle alone delays or prevents the registration of up to 10 million children. And the rate of registration has declined since China discontinued its practice of rationing food based on the number of registered family members.

Africa's most populous country, Nigeria, with an estimated 5 million births a year, doesn't know exactly what percentage of births are registered. As in many other countries in Africa, where formal registration began later than in other regions, the vital statistics systems exist, but their reliability and efficiency are hampered by a host of problems: insufficient funding, inadequate technology, poorly trained staff, lack of publicity and a corresponding lack of public awareness of the importance of registration.

Stateless by design

Threatening as it is to be without a birth certificate in a settled community, to be denied proof of identity outside the borders of one's home country is to be consigned to the no man's land of statelessness. The obstacles to registration can be insurmountable for a child born in a State whose borders are splitting apart, or in a refugee camp, or into a family made stateless by discrimination due to its ethnic heritage or religious beliefs. And the failure to register such children adds to

their vulnerability by interfering with the fulfilment of their other rights.

The doors to participation in mainstream society have long been closed to most of the 5 million to 8 million Romanies, or Gypsies, in Central and Eastern Europe. As a result, only about 7,000 of Croatia's 60,000 to 100,000 Romanies are registered.

The right to a name and nationality has been jeopardized for countless millions of children unfortunate enough to be born in countries undergoing various forms of political turmoil: Kurds living in Syria, Tatars in Ukraine, Russians in Estonia and Latvia, minority groups or foreigners in Bhutan, Cambodia, Kuwait, Myanmar, Pakistan, the countries of former Yugoslavia, the 3 million Palestinians around the Middle East — the list goes on and on.

Children abandoned in such upheavals and who lack papers cannot be legally adopted, which condemns them to lives of institutionalization, or worse.

Sometimes low levels of registration result from a government's deliberate and effective efforts to block it. In one of the most telling legacies of apartheid, in 1993 only about 13 per cent of the black population was registered in South Africa, a country with a thoroughly modern, computerized registry that for many years had managed to register all of its white citizens.

International human rights law is clear: Children have the *right* to a nationality. It can be acquired either from their parents or from the country of their birth. The Convention on the Reduction of Statelessness mandates that children acquire nationality from the country of their birth if they do not acquire it from another country (such as their parents' country of birth).

In fact, the right to a name and nationality has a long and honourable pedigree. The Universal Declaration of Human Rights, adopted by the United Nations in 1948 and now celebrating its 50th anniversary, states that "everyone has the right to a nationality" and that "no one shall be arbitrarily deprived of his nationality." This right has been addressed in 10 international agreements, most recently the Convention on the Rights of the Child, in force since 1990 and now ratified by every country on earth except Somalia and the United States.

The Convention requires that countries both honour children's right to a name and nationality when they are born and protect that right as they grow up. "Where a child is illegally deprived of some or all of the elements of his or her identity," stipulates article 8, "States Parties shall provide appropriate assistance and protection, with a view to speedily re-establishing his or her identity."

Discrimination against women also comes into play in birth registration, as it did for me. In 1983, I married an expatriate in my home country, Botswana. We have lived there ever since, but when my children were born in 1984 and 1987, national law required them to take my husband's nationality — although they would have been granted dual citizenship if their father had been the Botswanan citizen rather than their mother. The law effectively forced my daughter and son to live as expatriates, preventing them from obtaining the full range of services a citizen of my country enjoys, such as voting or receiving tuition at the national university. We challenged that law, and after a long legal battle, we won the case in 1992 on the grounds that it violated a woman's right to pass on her nationality to her children. Three years later, Botswana changed its nationality law.

UN/DPI 6107/Mahasa

In many countries, a birth certificate is required for voter registration, so people without proof of birth may be disenfranchised. This Mozambican woman proudly displays her voting card while waiting to vote in the country's first democratic election, in 1994.

Children's best interests

The case also had serious implications for child rights. By denying my children the option of Botswanan citizenship simply because their mother married a foreigner, the law was denying them the full right to an effective nationality. And by mandating that they take their father's nationality, it ignored article 3 of the Convention on the Rights of the Child, which calls for "the best interests of the child" to be a primary consideration in all actions concerning children.

In 1996, before I became a judge, I brought a case that challenged Botswana's law stipulating that children born out of wedlock belong exclusively to their mothers, the other side of this coin being that fathers in such situations have limited, if any, responsibility for their children. As a result of this legal case, such children now have limited rights to support, but as of yet they have no right to inheritance or to have their father's name entered on their birth certificates.

Thanks to the collective force of women's activism and the growing power of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), many patri-

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archal national laws have been rewritten in the past few years to give women the right to pass their nationality on to their children, as required by article 9. *(See story, page 9.)*

The issue of the nationality of a child born to parents from different countries is a particular concern when national laws treat men and women differently, such as some of those countries with legal systems based on Sharia, or Islamic law.

For instance, birth certificates in Jordan state both the father's and mother's nationality. However, Jordanian children are given the mother's nationality only if the father's cannot be legally identified. Women's human rights groups are now leading an effort to place Jordan's citizenship rules under secular law and grant women the right to pass on nationality to their children.

Egypt's reservation to article 9 does not acknowledge the difficulties faced by children who become foreigners in their own country simply by being assigned their father's nationality. Rather, the reservation states: "It is clear that the child's acquisition of his father's nationality is the procedure most suitable for the child and that this does not infringe upon the principle of equality between men and women, since it is customary for a woman to agree, upon marrying an alien, that her children shall be of the father's nationality." Such an assumption violates not only women's rights but also children's right to citizenship.

Making good on promises

These are obstacles that commitment, technology and public information campaigns can, and must, overcome, and some nations have begun taking small steps towards doing so. Under the auspices of the UN Statistical Division and a consortium of UN agencies, training workshops have been held for registrars throughout the world during the past six years to improve civil registration systems. Registry offices are being strengthened and upgraded, and some are moving towards computerization. Public information campaigns have begun in a number of countries.

More than 30 countries make extra efforts to reach children in rural areas. Travelling registrars issue birth certificates in, among others, Argentina, Ecuador, Iran, Thailand and Zimbabwe. Mozambique, in order to register children born during its civil conflict, began a mobile campaign shortly after the peace accord in 1992.

Chile has a state-of-the-art mobile registration unit with a computer connection to the registry in the capital. In 1996, Romania passed a law obligating doctors to initiate the registration process for babies they deliver who are subsequently abandoned in the hospital. In the Philippines, as part of an effort to improve awareness, each February is designated as Civil Registration Month.

A number of countries have health officials or registry staff begin the process right in the hospital, among them Chile, Costa Rica, Cuba, Dominican Republic, Egypt, El Salvador, Equatorial Guinea, Ghana, Libya, Madagascar, Mali, Myanmar, South Africa and Uruguay. To reach children born out of hospitals, traditional birth attendants in Ghana are being trained to register the babies they deliver.

In Peru, judges, lawyers, registrars, educators and staff from grass-roots organizations have attended seminars on civil registration. In Ecuador, mobile brigades have been organized to register children in poor neighbourhoods, and Nicaragua has focused on migrants from rural areas and children from indigenous neighbourhoods.

But these are isolated efforts and they are not enough — as demonstrated by most nations' uncertainty about the percentage of registered births. Governments must provide the resources to develop registration systems, and citizens must continue to press their governments by challenging laws that discriminate against the child's right to a full nationality.

Being registered at birth is the first step on life's path. For children denied a birth certificate, the path will be a rocky one. We must vow to make sure that every child born on earth has this precious birthright, a ticket to citizenship. I can think of no better commemoration of the 50th anniversary of that solemn promise to humanity, the Universal Declaration of Human Rights. ■

By providing information about the number of children in a country, birth registration helps governments plan services, such as schools. These youngsters attend school in a village in Turkmenistan, which has a birth registration rate of at least 90%.

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Ending patriarchal nationality laws

A woman's right to pass on her nationality to her children is protected by article 9 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). It states that women shall be granted "equal rights with men with respect to the nationality of their children."

Yet at least 14 countries that have ratified CEDAW have lodged reservations to article 9, indicating that they will not be bound by it; Turkey has entered a declaration to a similar effect.

In most of the countries that have lodged reservations, a woman may pass on her nationality to her child if the father is unknown. But when a female national is married to a foreigner, her child must either take the father's nationality or remain stateless.

In that case, the child becomes a foreigner in the country of her or his birth and may be excluded from free schooling, health care and other services provided to citizens.

Since CEDAW came into force in 1981, at least 10 countries have changed their citizenship laws to give women the right to pass on their nationality to their children. Japan and Switzerland amended their laws on this issue in 1985; Italy in 1987; Viet Nam in 1988; Luxembourg and Malta in 1989; Thailand in 1991; India in 1992; South Africa in 1994; and Botswana in 1995.

Before its reform in 1992, India's legal system, based on colonial practice, granted citizenship only according to the father's nationality. In Bangladesh and Pakistan the same 'inherited' system is still in place.

In fact, just because a country has not lodged a formal reservation to article 9 does not guarantee that citizenship laws allow women the right to pass nationality on to their children or that governments support that right.

Most, but not all, countries that base their legal systems on Islamic Sharia have lodged reservations to article 9. In Egypt, it is estimated that several hundred thousand children have been prevented from obtaining Egyptian nationality because their fathers are citizens of another country.

These children must repeatedly apply for short-term residence and are required to pay (in foreign currency) for education in government schools and universities, which is free for Egyptian citizens.

Countries with reservations to article 9 of CEDAW:

- Algeria
- Bahamas
- Cyprus*
- Egypt
- Fiji
- Iraq
- Jordan
- Kuwait
- Lebanon
- Malaysia
- Maldives**
- Morocco
- Rep. of Korea
- Tunisia

* Reservation will be withdrawn upon amendment of relevant law.

** Reservation to all articles contrary to Sharia.

Sources: UN Office of Legal Affairs, 1998; P. Boland (editor, *Annual Review of Population Law*, Harvard University).

Birth registration: A first step

Birth registration is the community's first recognition of a child's legal existence. Children have a right to a birth certificate, and in many cases they must be registered to gain access to the country's basic services.

In many countries, registration systems are not yet fully implemented, forcing governments to overlook their own rules requiring proof of birth to access services. This is especially the case outside cities, where rates of registration typically are lower. For example, Kenya, Myanmar, Pakistan and Uganda officially require a birth certificate for school enrolment but do not generally enforce that regulation in rural areas. In a number of countries, including Colombia and Turkey, the birth registration rate noticeably increases when children reach school age because they must be registered to enrol in school.

But even when children do receive services in the absence of a birth certificate, the lack of registration means that their needs are not anticipated. They are more likely to miss out on school and health care and they are more vulnerable to exploitation.

A birth certificate is required for:*

	Immunization	Health care	School enrolment	Marriage
Algeria	No	No	Yes	Yes
Argentina	No	No	Yes	Yes
Bangladesh	No	No	No	No
Brazil	No	No	Yes	Yes
China	No	No	Yes[2]	Yes[2]
Colombia	Yes	Yes	Yes	Yes
Congo, Dem. Rep.	No	No	Yes	No
Egypt	Yes	No	Yes	No
Ethiopia[3]	–	–	–	–
India	No	No	Yes	No
Indonesia	No	No	Yes	Yes
Iran	No	No	Yes	Yes
Iraq	Yes	No	No	No
Kenya	Yes	No	Yes	No
Mexico	Yes	Yes	Yes	Yes
Morocco	No	No	Yes	Yes
Myanmar	Yes	No	Yes	No
Nepal	No	No	No	No
Nigeria	No	No	Yes	–
Pakistan	No	No	Yes	No
Peru	No	No	Yes	Yes
Philippines	No	No	Yes	Yes
Russian Fed.	Yes	Yes	Yes	No
South Africa	No	Yes	Yes	Yes
Sudan	No	No	Yes	No
Tanzania	No	No	Yes	No
Thailand[4]	Yes	Yes	Yes	Yes
Turkey	No	No	Yes	Yes
Uganda	No	No	Yes	No
Ukraine	Yes	Yes	Yes	No
Uzbekistan	Yes	Yes	Yes	No
Viet Nam	No	No	Yes	No
TOTAL	10	7	28	14

* Among countries with 75% of the world's under 18 population.

[2] A birth certificate is required only when the person is under the legal age of marriage: 16 for girls, 18 for boys.

[3] An identification card is required but a residence card may suffice.

[4] No registration system.

[5] A house registration card is needed for most services and a birth certificate is needed to obtain a house registration card. A child may attend school but cannot receive a graduation certificate without a registration card.

Source: UNICEF, 1998.

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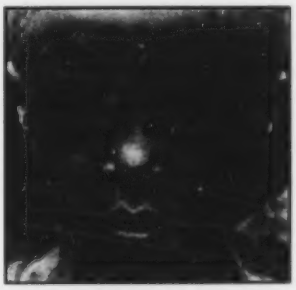
BIRTH REGISTRATION

A birth certificate is a child's proof of identity and represents the first acknowledgement of his or her significance to the country. Proof of birth is needed for a number of services, and it offers a degree of legal protection. But too few developing nations take birth registration seriously, and rates vary widely within and between countries. Some nations do not even know what percentage of their citizens are registered. All developing countries need to assess their status, set targets for improvement and make sure they fulfil them.



Birth registration: Flawed figures

"The child shall be registered immediately after birth..." mandates article 7 of the Convention on the Rights of the Child. But despite almost universal ratification of this human rights treaty, one third of all births — about 40 million babies — go unregistered every year. While the industrialized nations register virtually all their children, civil registration systems are still rudimentary in many developing countries. Many are uncertain as to what proportion of their children are registered; some do not even have a registration system. For these reasons, the league table presents broad percentages of coverage rather than precise numbers.

The problems in estimating registration coverage include the following:

- While many countries have estimates of the percentage registered, most of these estimates are approximate. Very few countries have made the effort to assess coverage objectively and thoroughly.
- Registration rates differ widely within many developing countries. Cities tend to have higher rates than rural areas because civil registries are centralized. Similarly, babies born in hospitals are more likely to be registered than babies born at home because the registration process often takes place in the hospital.
- In many countries, ethnic minorities have lower rates of registration than the general population.
- Despite the fact that the Convention on the Rights of the Child calls for children to be registered "immediately after birth," many children are registered later in life, such as when they enrol in school.
- Civil registration systems lag in sub-Saharan Africa because of underdevelopment. In some countries, the leftover structures of colonial governments, which in many cases did not register the black population, have impeded progress on registration.
- The responsibility for registering children at birth typically falls on mothers, adding another burden to their heavy workload. This is especially true in Africa and southern Asia where more than half of babies are born outside of hospitals.

The evidence of improvement in birth registration coverage is mixed. While many countries report increasing rates of registration, coverage is falling in others. Rates in Kyrgyzstan and Tajikistan have declined in the past 10 years due to the disintegration of administrative structures following the breakup of the Soviet Union. China's registration system is being strained by an increasingly mobile population.

Registration must not be left to chance. Better quality and more timely information is vital to fulfilling children's rights and for national planning, and it is not that difficult to obtain. Countries including Brazil, Pakistan and Turkey have recently used household surveys to assess birth registration coverage.

These surveys also highlight disparities within countries. In Pakistan, for instance, Punjab Province registers 88% of children, while in North-West Frontier Province the figure is only 46%. Turkey's western region has a coverage rate of 84%, compared to the figure in the east — 56%.

So far, too few countries have taken birth registration seriously. All developing countries need to assess their current status, set specific targets for improvement and follow up with regular monitoring.

SUB-SAHARAN AFRICA

	LEVEL OF REGISTRATION
Mauritius	1
Gabon	2
Burundi	3
Gambia	3
Botswana	4
Cameroon	4
Chad	4
Ghana	4
Guinea	4
Kenya	4
Mali	4
Mauritania	4
Uganda	4
Zimbabwe	4
Angola	5
Guinea-Bissau	5
Lesotho	5
Liberia	5
Malawi	5
Mozambique	5
Niger	5
Rwanda	5
Sierra Leone	5
Zambia	5
Eritrea	6
Ethiopia	6
Namibia	6
Somalia	6
Benin	No data
Burkina Faso	No data
Central African Rep.	No data
Congo	No data
Congo, Dem. Rep.	No data
Côte d'Ivoire	No data
Madagascar	No data
Nigeria	No data
Senegal	No data
South Africa	No data
Tanzania	No data
Togo	No data

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MIDDLE EAST AND NORTH AFRICA

	LEVEL OF REGISTRATION
Algeria	1
Egypt	1
Iran	1
Israel	1
Jordan	1
Kuwait	1
Lebanon	1
Libya	1
Syria	1
Tunisia	1
U. Arab Emirates	1
Morocco	2
Turkey	2
Sudan	4
Yemen	4
Oman	6
Iraq	No data
Saudi Arabia	No data

CENTRAL ASIA

	LEVEL OF REGISTRATION
Armenia	1
Azerbaijan	1
Kazakhstan	1
Kyrgyzstan	1
Tajikistan	1
Turkmenistan	1
Uzbekistan	1
Afghanistan	6
Georgia	No data

EAST/SOUTH ASIA AND PACIFIC

	LEVEL OF REGISTRATION
Australia	1
China	1
Japan	1
Korea, Rep.	1
Malaysia	1
Mongolia	1
New Zealand	1
Singapore	1
Sri Lanka	1
Thailand	1
Pakistan	2
Philippines	2
Indonesia	3
India	4
Myanmar	4
Bangladesh	5
Papua New Guinea	5
Cambodia	6
Bhutan	No data
Korea, Dem.	No data
Lao Rep.	No data
Nepal	No data
Viet Nam	No data

AMERICAS

	LEVEL OF REGISTRATION
Argentina	1
Brazil	1
Canada	1
Chile	1
Costa Rica	1
Cuba	1
Dominican Rep.	1
El Salvador	1
Guatemala	1
Honduras	1
Jamaica	1
Mexico	1
Trinidad/Tobago	1
United States	1
Uruguay	1
Colombia	2
Panama	2
Paraguay	2
Peru	2
Venezuela	2
Bolivia	3
Nicaragua	3
Ecuador	No data
Haiti	No data

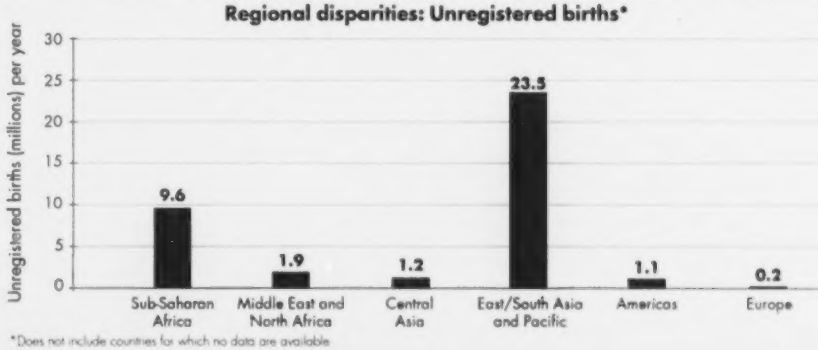
Source: UNICEF

Every year, about 40 million babies go unregistered — one third of all births.

WHAT THE RANKINGS MEAN

1. **90% and more registered**
2. **70% to 89% registered**
3. **50% to 69% registered**
4. **30% to 49% registered**
5. **Less than 30% registered**
6. **No birth registration system**

Regional disparities: Unregistered births*



*Does not include countries for which no data are available
Source: UNICEF

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COMMENTARY

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Immunization: Going the extra mile

Ralph H. Henderson, M.D.

Immunization is the greatest public health success story in history. Between 1980 and 1990, a massive effort raised coverage rates worldwide from 5 per cent to 80 per cent. But just as a new generation of vaccines is about to come on the market — capable of saving millions more children's lives each year, but at much greater cost — the momentum to sustain immunization is faltering.

Two decades ago, just 5 per cent of infants in developing countries were being vaccinated against the six major child-killing diseases. Today, about 80 per cent are being reached — a towering achievement.

Deaths from those six diseases (measles, tetanus, whooping cough, tuberculosis, polio and diphtheria) have been slashed by 3 million a year, and at least 750,000 fewer children are left blind, paralysed or mentally disabled. Thanks to a triumphant global eradication campaign, polio is expected to follow smallpox into extinction by the end of this decade, eliminating the need for vaccination — and saving the governments of the world $1.5 billion in vaccine, treatment and rehabilitation costs every year.

By any standard, the international immunization effort is the greatest public health story in history. And immunization is also a bargain, with a price tag of just $15 per child: $1 for the six original vaccines plus the expenses of delivery to some of the least accessible places on earth. The impact of these modest investments on the lives of children and their parents is momentous.

The future holds even greater promise. A new generation of vaccines, about to make its entrance, holds amazing potential: vaccines against increasing numbers of diseases; one-shot vaccines that eliminate the need for booster shots; vaccines aimed at ever-younger infants, to protect them at a vulnerable age; and even vaccines that are simply spread on the skin.

Fourteen new or improved vaccines have entered the market since 1980, and dozens more are in the pipeline. They will prevent some of the most pernicious killers of children, such as diarrhoeal diseases and acute respiratory infections. Experts predict that, by early in the next millennium, these antigens could be saving the lives of up to 8 million children each year.

The basic vaccines already available to combat the 'big six' diseases could save up to 2 million children still dying from vaccine-preventable disease every year — *if* every child were reached.

And there's the catch. Despite the low cost of the existing immunization package, many of the world's poorest children, those most vulnerable to disease, are already falling through the vaccine net.

Sub-Saharan Africa fares the worst: Each year, almost half the children who should receive the necessary three doses of DPT vaccine to prevent diphtheria, pertussis (whooping cough) and tetanus do not. Although coverage rates in the rest of the world are higher, the fact remains that 26 million infants worldwide annually do not receive their three DPT shots.

If we don't reach these children now, with the vaccines already available, what are the prospects of reaching them with the vaccines of the future?

To safeguard the health and well-being of children, two things need to happen. First, those children not receiving the existing low-cost vaccines must be reached. Second, we must take steps now to ensure that these children are not bypassed by the wonders of the next generation of vaccines, which will cost many times more than those now in use.

The 'missing' vaccines

It should be one of the biggest news stories of all time: the prospect of vaccines that could save the lives of 8 million children each year, or 22,000 children each and every day. Instead, there is silence. Could the reason be that these 8 million are, overwhelmingly, the unseen, unheard children of the poor?

The unconscionable fact is that some vaccines already on the market have never even made it to their intended targets. The antigen for hepatitis B — a disease that kills around 1 million people each year — has been available since the early 1980s. But many of the countries that need it, including Azerbaijan, Benin, Cambodia, Tanzania and Viet Nam, cannot afford this vaccine, even though its cost has plunged from $150 to less than $1 per dose.

Yellow fever is again menacing Africa and Latin America, with Gabon, Ghana and Nigeria suffering outbreaks in 1994, and Liberia and Peru in 1995. In each case, expensive emergency immunization efforts were needed to stop the spread of the disease.

Five years ago, public health officials recommended that the hepatitis B and yellow fever vaccinations be added to the basic immunization package, along with nutritional supple-

Dr. Ralph H. Henderson is Assistant Director-General of the World Health Organization. As Director of the Expanded Programme on Immunization at WHO from 1979 to 1989, he was the architect of the global effort that raised immunization rates from 5 per cent around 1980 to 80 per cent in 1990. In a public health career spanning more than 30 years, much of it with the US Public Health Service, Dr. Henderson previously made major contributions to smallpox eradication and the control of venereal diseases.

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ments of vitamin A. Yet few of the 34 at-risk countries in Africa have been able to include the yellow fever vaccine in their immunization programmes, even at the UNICEF-discounted price of only 17 cents. As demonstrated in 1994 and 1995, funds can be found to contain the disease when it begins to spread — but not, apparently, to keep it from getting into circulation in the first place.

Other vaccines falling into cost-benefit quagmires are those against *Haemophilus influenzae* type B (Hib disease), a leading cause of pneumonia and meningitis among young children, and rotavirus, the diarrhoea-inducing microbe blamed for the yearly deaths of almost 1 million children.

Such problems cast a shadow over prospects for two future life-savers: vaccines against malaria and HIV/AIDS. The development of a malaria antigen is proving both slow and costly, and work on a vaccine against HIV infection is still not receiving the support it requires. The problems with both vaccines may in part be due to the reluctance of manufacturers. They face daunting scientific challenges compounded by financial and political concerns about vaccines almost certain to be beyond the reach of the countries that need them most.

Where we stand

The success of the global immunization effort is unprecedented. But we need to take a closer look at this achievement. The tremendous gains against polio, for example, are tempered by the continuing threat of other diseases, such as measles.

Polio is without question the star of the current international immunization effort. Only 3,234 cases were reported worldwide in 1997, down from 23,000 cases seven years earlier, and the western hemisphere has been polio-free for seven years. Although underreporting remains a problem, it is clear that polio is on the run. In 1997 alone, more than half the world's children under the age of 5 were vaccinated during massive campaigns that, along with routine immunization efforts, may wipe the disease from the face of the planet within the next two years.

Upcoming vaccines could save 8 million lives a year — but at a price.

Such campaigns also galvanize political commitment, bring in extra funding and increase awareness of the importance of routine immunization and other basic child health measures. For instance, at least 34 countries use National Immunization Days as an opportunity to distribute vitamin A supplements widely. Boosting vitamin A levels in children who are deficient in this vital micronutrient can cut child deaths by about one quarter.

But there is another immunization story, a largely untold one. It is the story of the never-ending battle to raise and maintain basic immunization rates; to build the capacity of local and national systems so they can vaccinate one year's generation of 130 million babies on five separate occasions, then do it all over again the next year, and the next; and to convince families and communities that starting and continuing immunization is crucial to their children's health.

The relentless attacks of measles, which kills more children than any other disease currently preventable through vaccination, give some idea of the scale both of the progress already made and the problems that remain. The overall measles vaccination rate for developing countries now hovers at 77 per cent of children under the age of 1, and two thirds of all countries have already reached the year 2000 goal of cutting the number of measles deaths by at least 95 per cent.

But measles continues to thrive in the cities of Africa and Asia, especially in deprived neighbourhoods. Just 20 countries now account for 85 per cent of measles deaths of children under the age of 5. That means about 722,000 children are dying in those countries each year, half of them in Africa and 230,000 in India alone. In addition, measles immunization coverage has remained static or slipped in 32 of the 44 poorest countries since 1990, including Burundi (25 per cent decline in coverage), Papua New Guinea and Yemen (23 per cent), Malawi (14 per cent), Benin (13 per cent) and Mali (12 per cent).

Yet some of the poorest nations on earth are actually making the greatest strides. Cambodia, for example, has more than doubled its measles immunization rate, from just 34 per cent in 1990 to 72 per cent in 1996. Guinea's measles coverage rate stands at 61 per cent, compared to only 18 per cent in 1990.

These gains show what can be achieved when the national will is truly committed and when strong one-off campaigns are backed by vigorous routine immunization. Thanks to concerted efforts in the 20 hardest-hit countries, the global neonatal tetanus death toll has fallen from 400,000 to 280,000 in just seven years.

There is a message here, not only for developing countries, but for the industrialized world.

After nearly eliminating diphtheria, the countries of the former Soviet Union were rocked by epidemics in the early 1990s, sparked by plunging economies, armed conflict, irregular supplies of vaccines and massive population movements from the countryside to the cities. The number of cases soared, from under 2,000 across the region in 1990, to over 47,000 by 1994. Soon after, the epidemic spread to other European countries, including Bulgaria, Germany, Norway and Poland. The international community had to step in, and all the countries of the former Soviet Union except Belarus and the Russian Federation still depend on outside assistance for vaccines. The painful lesson is that if we let up our efforts for a minute, we pay for a very long time.

Staying on track

Some of the poorest nations are moving mountains to immunize their children, while other comparatively wealthy nations seem unable or unwilling to do so. The world as a whole is not doing all it can to make vaccines available to the children who need them. That is not only a failure of leadership — it is a moral outrage.

Immunizing children is not a matter of charity, it is a matter of fulfilling a fundamental human right. Countries that ratify the Convention on the Rights of the Child, the most widely ratified human rights treaty in history, are required to "ensure to the maximum extent possible the survival and development of the child" and must take "appropriate measures...to ensure the provision of...health care." These rights became tangible goals at the World Summit for Children in 1990, when the leaders of over 70 countries promised to reach and sustain coverage levels of at least 90 per cent against the main vaccine-preventable diseases by the year 2000.

When something becomes a right, it means that *every* child is entitled to it, not just those who are easy to reach. So national immunization plans must address not just the first 80 per cent but also the last 20 per cent: institutionalized children, children living on the

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streets, the hill tribe children in Thailand, the Romanies in Bulgaria and Romania, the isolated villagers in Nigeria.

Many developing countries made spectacular progress throughout the 1980s. But some are finding it difficult to keep up the momentum, and extremely hard to go the extra mile needed to reach the remaining children. Togo, for example, managed to push its measles rate up to 65 per cent in 1995, only to see it fall to 48 per cent in 1996. Guinea-Bissau's rate fell from 65 per cent in 1994 to 53 per cent just two years later.

Such figures lie at the very core of sustainability. A country needs the enduring capacity to immunize each new generation of babies; to bolster the health infrastructure, the staff and the supply of affordable vaccines to keep up the system year after year. But, like the refrigerators and other parts of the 'cold chain' bought during the massive immunization drive of the 1980s, momentum is showing signs of wear in some quarters. The technical and political structures must be maintained or immunization rates will plummet, with disastrous results.

That is why the Children's Vaccine Initiative, launched in 1990, is setting out to improve the world's supply of existing vaccines. Originally the brainchild of five sponsoring agencies — WHO, UNICEF, UNDP, the Rockefeller Foundation and the World Bank — the Initiative is now stimulating a global dialogue among governments, donors, vaccine manufacturers, researchers and immunization programme managers.

Another way forward is the vaccine-financing strategy, which UNICEF and WHO launched in 1994, which encourages governments to assume responsibility for their own vaccine needs. The strategy establishes financing targets based on relative wealth per capita so that donor funds can be concentrated on the neediest countries.

Countries are grouped in tiers, ranging from the very poorest, such as the Lao People's Democratic Republic and Mozambique, which pay only a token share of vaccine costs, to countries like Malaysia and Turkey, which received assistance only for the first year and are now self-supporting.

By 1996, 25 per cent of the poorest countries were meeting their minimum targets for vaccine self-sufficiency, compared with only 2 per cent in 1990, as were 90 per cent of the countries where assistance was phased out. Many countries are paying for or producing their own vaccines, including Brazil, China, Egypt, India, Mexico, Pakistan, the Philippines and most countries in South America. Developing countries now produce more than half the vaccines used for national immunization programmes.

Uganda, one of the world's poorest nations, is financing about 35 per cent of basic vaccines. Even in the midst of political and social upheaval, Burundi has managed to continue its support for vaccine funding, contributing $50,000 towards the cost of immunization in 1997.

A new scheme for vaccine financing has been launched by the European Union, together with the Governments of Burkina Faso, Cape Verde, Chad, Mali, Mauritania, Niger and Senegal, to ensure that national budgets have a specific line item for vaccine purchases. To encourage this effort, the EU is providing support directly to these countries' national budgets, which now include vaccines as an integral part of overall health expenditures.

This support for immunization cannot be cemented into the foundation of the worldwide immunization effort without the unshakeable political commitment of each country's leaders. These leaders must assess their priorities and examine the true value of a vaccine — to a child, to a family, to a nation. The world needs to ask how is it possible that something so cost-effective and readily available is not reaching *every* child.

UNICEF/96-0071/Davies

By supporting regular immunization, two thirds of all countries have cut the number of measles deaths by at least 95%. Rwandan children in a refugee camp in Tanzania wait to be vaccinated, immunization cards in hand.

Missing the poorest

The new vaccines present great challenges as well as opportunities. At current levels, funding will be insufficient to get them to the countries that are home to the poorest 10 per cent of the world's children and that bear the heaviest burden of disease. Donors contribute around $21 million each year to these countries for the six original antigens.

The addition of the vaccines for hepatitis B and yellow fever would push this bill up to $70 million. Add Hib and rotavirus vaccines, and one to tackle pneumococcal disease, and the price rises to at least $381 million. With the cost of overhauling the cold chain to keep vaccines at the right temperature, improving delivery capacity and supporting safe injection procedures, the world is looking at a total bill of $700 million each year.

That $700 million may sound expensive — but it comes to just 12 cents per person worldwide. Compare that to the $139 per person spent globally on the military machine in 1996 and the world's priorities become clear. In a $28 trillion global economy, economic resources are not the issue — priorities are.

So far, the countries of the world, developing nations and donors alike, simply are not doing all they can to get this medical miracle to the children who need it. We in the public health community have a duty to bring this outrage to the world's attention. The lives of millions of girls and boys are in our hands. ■

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MEASLES IMMUNIZATION GAP

Measles kills more children than any other vaccine-preventable disease — over 800,000 every year. The percentage of children immunized against measles before their first birthday is therefore a good indication of whether countries are fostering the survival and growth of their youngest citizens. This year's health league table addresses measles immunization — but from a new angle. Instead of the percentage of children immunized against measles, it shows the percentage *not* immunized. These are the children whose fundamental human right to health care has been denied.

Immunization statistics: Reality check

How can governments hope to fulfil the needs of their children if they do not know precisely what those needs are? Participants at the 1990 World Summit for Children addressed this fundamental problem, calling for countries to establish mechanisms for the regular collection, analysis and publication of data concerning the well-being of their children.

There is no better indicator of success in maintaining such information than a country's record on immunization, the most regularly collected and closely watched statistic. But assessing even these figures is a complicated process.

Virtually every country maintains data on child immunizations. The most common record is the notation a health centre makes each time a child is immunized. The accuracy of these 'routine reports' can be flawed by the complexities of communicating the information up the chain of command from the local clinic to the health ministry. Routine reports are therefore periodically supplemented by surveys, which generally provide better data but are performed less frequently because of their expense. As a result, publications such as *The Progress of Nations* base their figures on a combination of the two.

Working with these statistics reveals the complexities of data gathering. For instance, UNICEF figures reveal that, in 44 countries, routine clinic reports show immunization rates that are at least 10 percentage points higher than rates obtained from surveys. Elsewhere, this discrepancy is reversed: In 17 other countries, routine clinic reports give rates of coverage at least 10 percentage points lower than survey data.

The implications of these variances are troubling. In India in 1992, for example, a survey found that 10 million fewer children under 1 had received the third dose of vaccine against diphtheria, pertussis and tetanus (DPT) than had been indicated in routine clinic reports.

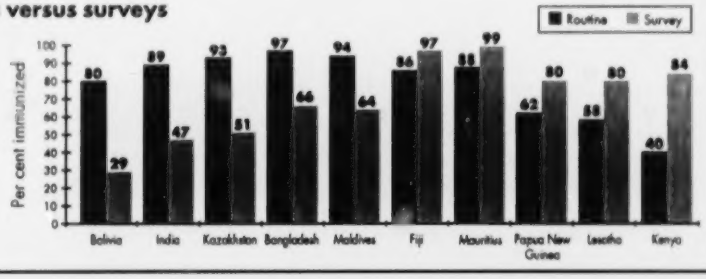
The opposite holds in Kenya. In 1996, the routine clinic reports showed that just 40% of children had received their third DPT shot, while survey records showed that 84% had — a difference of about 500,000 children.

If the 1996 immunization rates of the 40 largest countries were adjusted to account for the discrepancies between routine clinic reports and survey findings, worldwide coverage would be 10 percentage points less, or 70%.

Thus, even the 'best' statistic available to measure children's well-being can be flawed if countries do not give it the priority it demands. Governments must devote more resources to data gathering if they are to meet children's right to health.

Routine reports versus surveys

Difference between routine clinic reports and survey data, DPT3
(Countries with biggest discrepancies)



Sources: DHS, UNICEF and WHO.

SUB-SAHARAN AFRICA

1	Gambia	0
2	Botswana	18
3	Sierra Leone	21
4	Zimbabwe	23
5	Rwanda	24
5	South Africa	24
5	Zambia	24
8	Lesotho	27
9	Madagascar	32
9	Malawi	32
9	Tanzania	32
12	Mauritania	33
13	Uganda	34
14	Angola	35
14	Côte d'Ivoire	35
16	Guinea	39
16	Mauritius	39
16	Namibia	39
19	Benin	43
19	Mozambique	43
21	Burkina Faso	46
21	Ethiopia	46
▶	*Regional average*	*47*
23	Ghana	47
23	Guinea-Bissau	47
25	Senegal	49
26	Burundi	50
27	Togo	52
28	Cameroon	54
28	Central African Rep.	54
30	Nigeria	55
31	Liberia	56
32	Congo	58
33	Congo, Dem. Rep.	59
34	Eritrea	62
34	Gabon	62
34	Kenya	62
37	Mali	65
38	Somalia	67
39	Chad	72
40	Niger	79

MIDDLE EAST AND NORTH AFRICA

1	Kuwait	1
2	Jordan	2
2	Oman	2
4	Iran	5
5	Israel	6
6	Morocco	7
7	Libya	8
7	Saudi Arabia	8
9	Tunisia	14
10	Egypt	15
10	Lebanon	15
▶	*Regional average*	*16*
12	Syria	16
12	Turkey	16
14	U. Arab Emirates	17
15	Iraq	20
16	Sudan	25
17	Algeria	32
18	Yemen	49

CENTRAL ASIA

1	Azerbaijan	1
2	Kazakhstan	3
3	Uzbekistan	8
4	Armenia	11
5	Tajikistan	20
▶	*Regional average*	*28*
6	Turkmenistan	34
7	Kyrgyzstan	35
8	Georgia	45
9	Afghanistan	58

EAST/SOUTH ASIA AND PACIFIC

1	China	3
2	Viet Nam	4
3	Korea, Dem.	6
4	Korea, Rep.	8
5	Mongolia	12
5	Singapore	12
7	New Zealand	13
8	Bhutan	14
8	Myanmar	14
8	Sri Lanka	14
11	Thailand	15
▶	*Regional average*	*17*
12	India	19
12	Malaysia	19
14	Pakistan	22
15	Cambodia	28
15	Philippines	28
17	Japan	32
18	Indonesia	37
19	Lao Rep.	39
20	Bangladesh	41
21	Nepal	55
22	Papua New Guinea	56
23	Australia	No data

AMERICAS

1	Argentina	0
2	Jamaica	1
3	Canada	2
3	Cuba	2
5	El Salvador	3
6	Colombia	5
7	Chile	7
8	Honduras	9
9	Panama	10
10	United States	11
11	Trinidad/Tobago	12
12	Bolivia	13
13	Costa Rica	14
14	Uruguay	15
▶	*Regional average*	*19*
15	Paraguay	19
16	Ecuador	21
17	Dominican Rep.	22
17	Nicaragua	22
19	Mexico	25
20	Brazil	26
21	Peru	29
22	Guatemala	31
23	Venezuela	36
24	Haiti	69

WHAT THE TABLE RANKS

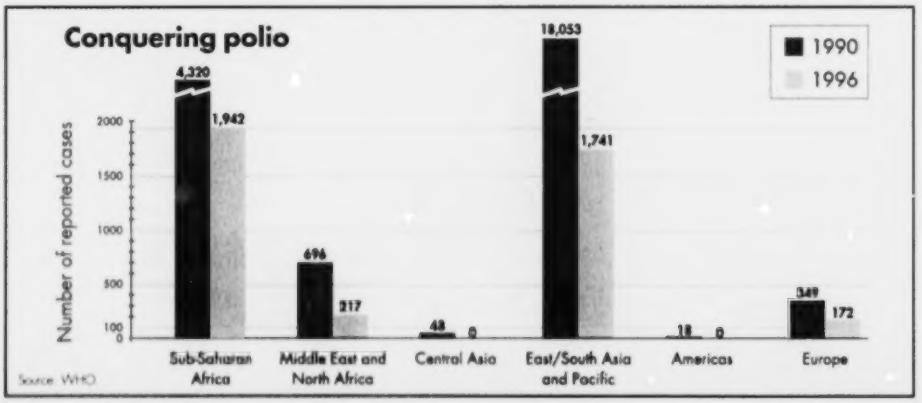
Percentage of children under 1 ***not*** immunized against measles.

Sources: UNICEF and WHO

DEVELOPING WORLD AVERAGE

23%

Immunization is the world's greatest health bargain: $15 to protect a child, including all the costs of delivery.



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Neonatal tetanus death toll cut by a third

In 1990, about 360,000 newborn babies died of neonatal tetanus in the 20 countries where it was most prevalent. Concerted efforts to eliminate the disease have dragged that figure down to 224,000, drastically reducing the toll of an insidious disease that attacks infants during the first days of life — its earliest symptom, a facial spasm, often tragically mistaken for a baby's first smile.

Brazil recorded the greatest progress, slashing the death toll by 99%, from almost 6,000 deaths in 1990 to only 80 in 1997. Viet Nam did nearly as well, with deaths down by 94%. In terms of sheer numbers, China recorded the greatest cut: from more than 75,000 infants in 1990 to just under 14,000 in 1997, a fall of 82%.

Not all the news is good, however. Deaths in Nigeria surged from 23,000 to 38,000, the largest absolute increase worldwide, up by 62%.

Neonatal tetanus results from tetanus spores being introduced through poor hygiene during childbirth, often exacerbated by traditional childbirth practices, such as the use of clarified butter or even cattle dung to 'heal' the umbilical stump.

While the global goal of eliminating neonatal tetanus by the end of 1995 was not reached, the disease could still be eliminated by the turn of the century with increased political commitment. Additional funding of around $30 million would also be needed to target every high-risk area on the planet. New developments in immunization technology could prove invaluable, allowing non-health personnel to perform immunizations.

UNICEF/91-48801/Lemoyne

Concerted efforts have dramatically cut neonatal tetanus deaths in most of the hardest-hit countries. Nigeria is an exception, with deaths up 62%. Nigerian women receive the tetanus vaccine, which will protect the children they bear.

Attacking neonatal tetanus

Success of 'top 20' in reducing death toll.

	1990 deaths	1997 deaths	Per cent change
Brazil	5,900	80	99
Viet Nam	6,200	400	94
China	75,700	13,700	82
Egypt	4,000	740	82
Uganda	7,500	2,200	71
Indonesia	22,800	7,100	69
Philippines	4,700	1,900	60
Kenya	5,100	2,500	51
Bangladesh	38,600	20,700	46
Niger	4,200	2,400	43
Ghana	4,000	2,400	40
Myanmar	4,400	3,200	27
India	77,700	59,100	24
Pakistan	36,300	29,700	18
Nepal	6,700	5,800	13
Mozambique	3,900	3,600	8
Ethiopia	14,800	15,600	-5
Somalia	6,500	7,000	-8
Congo, Dem. Rep.	7,200	8,200	-14
Nigeria	23,400	37,900	-62
Total	**359,600**	**224,220**	

Source: WHO, 1998

Local hero: ORS production takes off

Almost half the countries responding to a recent survey have increased local production of oral rehydration salts (ORS), the lifesaving therapy for children threatened by diarrhoeal dehydration. A UNICEF survey of 65 countries has uncovered a welcome trend towards sustainability. Local production is increasing, and the share of ORS purchased by health ministries has risen by about 20% since 1994, another optimistic sign that oral rehydration therapy is becoming entrenched.

Bangladesh, Brazil, India and Nigeria — home to more than 160 million children under 5 — are among the 32 countries and territories reporting an increase in production in recent years. Two countries, Cuba and Mexico, are now producing enough ORS to export it to other countries. Among the 19 countries reporting no increase, several already produce adequate supplies of ORS for their needs.

In 1996, health ministries paid for more than half of the ORS used in 21 countries, up from 16 in 1994.

UNICEF offices in 20 countries reported no local production of ORS. While importing ORS may be more cost-effective for smaller countries, such as Swaziland, countries like Burundi, Cambodia and Iraq, where local production capacity has collapsed as a result of instability and war, raise concerns.

Diarrhoeal dehydration remains one of the world's great child killers, claiming over 2 million children under the age of 5 each year in developing countries. Up to 90% of these deaths could be prevented by replacing lost body fluids with ORS — a precise mix of salts, glucose and safe water — or with other recommended fluids. A sachet of ORS is economical, costing about 8 cents.

Making a local life-saver

Where production of ORS is increasing

Algeria	Nepal
Argentina	Nicaragua
Bangladesh	Niger
Bolivia	Nigeria
Brazil	Pakistan
Chile	Peru
Cuba	Philippines
Ecuador	Sudan
Egypt	Thailand
El Salvador	Turkey
Ethiopia	Uganda
Ghana	Venezuela
India	Viet Nam
Kenya	West Bank and Gaza
Lao Rep.	Yugoslavia
Mali	
Mexico	

Source: UNICEF, 1997

UNICEF/93-1363/Lemoyne

Home remedy: A sachet of oral rehydration salts mixed with safe water wards off life-threatening diarrhoeal dehydration.

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UNICEF/Schytte

First dates: Children, like these two in Guatemala, need five immunization visits in their first nine months of life.

Immunization drop-out: A sign of trouble

Just as a high rate of children dropping out of school points to problems in an education system, a high immunization drop-out rate — the percentage of infants who begin but do not complete the full course of six vaccinations in their first year — spotlights problems in a health system. Taking the BCG (tuberculosis) vaccination, given shortly after birth, as the starting point, and measles, administered at nine months, as the last vaccine a baby receives, it is possible to chart a country's success or failure in immunization.

In half of the 127 countries reporting on both of these immunizations, over 90% of babies immunized against BCG are also immunized against measles, suggesting that they have received the full course of vaccinations. This means that their parents have been able to take them to the health centre five times in the first year of life, a sign that immunization services are accessible, approachable and reliable.

In the 27 countries listed, however, at least 20% more infants receive BCG immunization than are vaccinated against measles. The Central African Republic records the highest drop-out rate of all reporting countries, almost 50%, with 94% of infants immunized against tuberculosis and only 46% against measles.

Only one industrialized country has a substantial drop-out rate: Japan, with a rate of 23%. Because of high health care and nutrition standards, measles is less of a threat to children in the industrialized world. However, it can be 'exported' to the developing world, putting children in the poorer countries at risk.

Dropping out

Countries where at least 20% more infants are immunized against TB than against measles:

	Percentage point drop-out between TB and measles immunizations
Dominican Rep.	20
Ecuador	21
Mozambique	21
Sudan	21
Zambia	21
Mexico	22
Peru	22
Turkmenistan	22
Japan	23
Algeria	26
Mauritius	26
Venezuela	26
Benin	27
Burundi	27
Nepal	28
Tanzania	28
Bangladesh	29
Malawi	29
Uganda	30
Senegal	32
Ethiopia	33
Papua New Guinea	34
Mali	34
Haiti	37
Togo	39
Liberia	40
Central African Rep.	48

Sources: UNICEF and WHO

Import taxes push up the price of bednets

Families at risk of malaria in at least 14 countries must pay more to protect themselves from the disease because their governments impose tariffs on imported bednets. The nets, which cost from $4 to $15 before import duties, are already a heavy expense for families in the poorest countries, where monthly earnings average $30 per capita or less. The tariffs, which range from 8% to 65%, make the financial burden even more severe.

Malaria kills over 1 million children under the age of 5 every year — a child every 30 seconds — in about 100 malaria-endemic countries around the world. Of the 74 countries responding to a recent UNICEF survey, 56 have bednets for sale. The nets are imported in 40 countries, and of these, 14 are known to impose tariffs. All but two of those countries are in sub-Saharan Africa.

Senegal has the highest tariff, at 65%, and six other countries in sub-Saharan Africa impose tariffs of 30% or more. Yet the region accounts for about 90% of all malaria-related deaths, and, on average, children suffer six bouts of the disease a year.

A study in the Gambia found that malaria deaths among children could be reduced by around 25% if children slept under treated bednets. Such protection against malaria-carrying mosquitoes is vital, as the disease is increasingly resistant to drug treatment, and the development of an effective vaccine is proving difficult.

Backing WHO's campaign to combat malaria, UNICEF has adopted three related goals: to have 20% of children under 5 in high-risk areas sleeping under bednets by the year 2000, 50% by 2005 and universal access to bednets by 2010. Steps to cut the cost of bednets, including the removal of import tariffs, will be crucial to the success of the campaign.

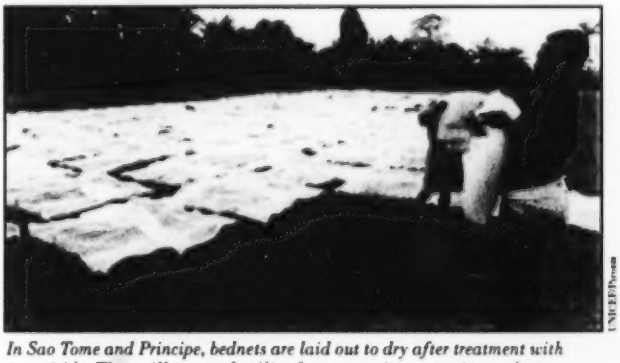
Taxing malaria protection

Countries known to charge duties on imported bednets:*

	Per cent tariff
Namibia	8
Eritrea	13
Yemen	15
Guinea	18
Guinea-Bissau	25
Zambia	25
Bolivia	30
Djibouti	33
Benin	36
Burundi	36
Cameroon	50
Mozambique	50
Gabon	53
Senegal	65

*Among 74 malaria-endemic countries responding to the survey

Source: UNICEF, 1998



UNICEF/Pirozzi

In Sao Tome and Principe, bednets are laid out to dry after treatment with insecticide. They will protect families from mosquitoes carrying malaria, which kills over 1 million children under age 5 each year worldwide.

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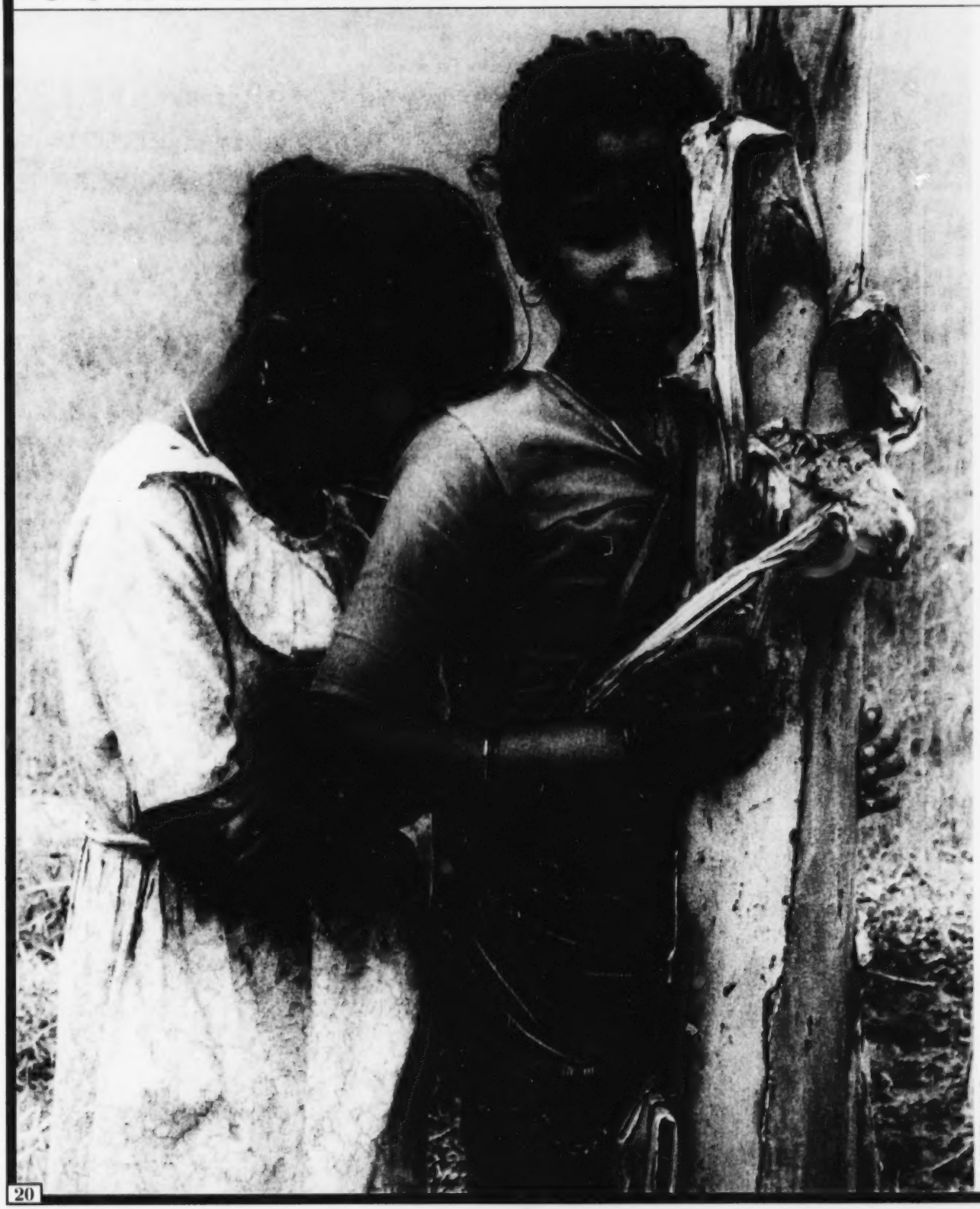
COMMENTARY



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Claiming the future

Geeta Rao Gupta

Adolescence has long been viewed as a distinct stage of life in the industrialized world. Now it is also emerging as a key interval between childhood and adulthood in the developing countries. Young people age 10 to 19 account for one sixth of the population on earth, making them a force for profound change. But they need the support of their families, communities and nations if they are to capitalize on their potential and avoid the perils ahead.

Adolescence should be the time of greatest hope and promise in life. It can be a springboard, producing self-confident young adults equipped with the knowledge they need to create a successful future for themselves and their societies. Or it can be the point at which everything goes wrong — when all their promise and potential are lost.

If it goes wrong for today's adolescents, it goes wrong for the world. The current generation of young people is the largest in history. Around 1 billion people — one out of every six on the planet — are between 10 and 19 years of age, 85 per cent of them in developing countries. And they face profound obstacles:

- In 1997 alone, around 3 million young people age 15 to 24 became infected with HIV, about two thirds of them girls.
- Girls age 15 to 19 give birth to 15 million babies a year, and more girls in this age group die from pregnancy-related causes than from any other cause.
- Around the globe, 73 million children age 10 to 14 are working — not counting the tens of millions, mostly girls, believed to be in domestic service.
- In developing countries, 59 per cent of girls and 48 per cent of boys are not enrolled in secondary school.

Geeta Rao Gupta is President of the International Center for Research on Women (ICRW), based in Washington, D.C. She has 20 years of experience in research and programme development, emphasizing women's health. Dr. Gupta has managed research programmes on women and AIDS, and on adolescent sexuality and nutrition. An international expert on HIV/AIDS, she serves on the board of the International AIDS Vaccine Initiative. Dr. Gupta holds a Ph.D. in social psychology.

For previous generations, the burden that fell on adolescent shoulders was at least foreseeable. Close on the heels of puberty came marriage, children and hard work to support the family. Young adults faced these challenges within the context of a familiar and supportive environment. Today, on top of the predictable problems of growing up, adolescents must confront the increasing challenges of exploitation and abuse, ethnic conflict and war. Communities are being uprooted, either literally, as families abandon the countryside in search of work, or figuratively, as media and other new influences disrupt familiar mores and traditions.

No longer children but not yet adults, adolescents are struggling to understand their own place in this confusing new world. Yet when it comes to government programmes and family decision-making, adolescents are hardly to be seen. After the age of 5, when their survival is relatively assured, they fall off the radar screen of health services, the girls showing up again only when they get pregnant; boys, at particular risk of accidents, violence and substance abuse, only receive attention when they break the rules. Just at the time of greatest potential and peril, adolescents are left to fend for themselves.

But this scenario is beginning to change. As the span of time between puberty and marriage has increased, as the HIV/AIDS pandemic has underscored the importance of equalizing the power in sexual relationships, as the child rights movement has taken hold, we have begun to realize that adolescence is a window of opportunity. Today's generation of young people, linked by threads as diverse as the tragedy of AIDS and the power of the media, can revolutionize the world — girls and boys together. Young people can be the catalyst to transform the past into a just and egalitarian future that works for both men and women, and for all of society.

The gender rules

Of all the issues that influence the adolescent experience, none is more profound than gender: the countless, unspoken cultural rules that govern the behaviour of females and males in every country on earth, almost from the day they are born.

Adolescent boys and girls are both vulnerable — but in different ways. They both face sexual pressures, but boys' sexuality is affirmed, while girls' is denied. They may both come from poor families, but in most cultures it is the girls whom poverty forces out of school, not the boys. They may both have to work, but for boys it is outside the home, expanding their horizons; for girls it is inside the home, restricting their experience. At adolescence, a boy faces the pressure of societal expectations to 'be a man', while a girl loses whatever freedom she had as a child.

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Those differences show up clearly in the division of responsibilities at home. Studies by the Population Council in Kenya, for example, show that 8- to 14-year-old girls work at domestic chores for 19 hours a week, boys for 14 hours. By the time they reach the 15- to 19-year-old age group, girls' workload has shot up to 32 hours a week, while the workload of boys has increased by just 4 hours. In Bangladesh, out-of-school boys spend just 12 minutes a day on domestic duties, compared to the 5 hours girls spend.

Nor are girls just working in their own homes. Ninety per cent of the children working as domestic servants — one of the most exploitive forms of child labour — are girls, and a survey in India found that 9 out of 10 households employing domestic servants preferred 12- to 15-year-old girls.

Family honour

In many societies, an adolescent girl is closeted in the home for the sake of the family's honour, which depends on her virginity and modesty. If she is out in the world, coming into contact with men outside her family, she risks her family's reputation. For this reason, young women are frequently married off as fast as possible. The median age of marriage for girls in Bangladesh is 14; in Senegal, 16; in Nigeria, 17; and in Egypt, 19.

These limits become visible in many secondary school classrooms, where a majority of the seats are filled by boys. Boys have higher rates of enrolment in secondary school than girls in about three quarters of developing countries outside Latin America. More than four times as many Yemeni boys attend secondary school as do girls, 36 per cent to 8 per cent. In Nepal, 49 per cent of boys are in secondary school, compared to 25 per cent of girls, and in Turkey, 67 per cent of boys attend, compared to 45 per cent of girls. *(See story, page 26.)*

A girl with minimal education, raised to be submissive and subservient, married to an older man, has little ability to negotiate sexual activity, the number of children she will bear or how she spends her time. In much of the developing world, women who have not completed primary school have two to three more children than those with some secondary education.

A young woman's lack of schooling also has a profound effect on the lives of her children. In Indonesia, the children of women with no formal schooling are almost three times more likely to die than those born to women with at least a secondary education.

Education is not a magic pill. But it can boost a young woman's confidence and teach her 'life skills', equipping her to make her own judgements. It may enable her to assert her right to choose whom and when she marries and to shift the skewed distribution of power between herself and her husband. Education can also provide vocational skills, potentially increasing her economic power, thus freeing her from dependence on her husband, father or brother.

However, that economic power often comes with a price. Most of the more than 1 million women employed in Bangladesh's garment factories begin working during adolescence. Forced by poverty to leave school, they accept the trade-off of a job that pays relatively well but exploits them, sometimes requiring them to work a 12-hour shift, seven days a week.

Although a job can raise self-confidence and provide the income needed to delay marriage, both the adolescent girl and society pay a high price in the long term when she drops out of school to go to work.

It is a tragic irony that adolescents were largely ignored by their elders until HIV/AIDS began to threaten their lives. Combining issues of sexuality, inequality, culture and poverty in complex ways, this disease encapsulates the adolescent experience in the late 1990s. Young people age 15 to 24 account for more than half of all new HIV infections, and teenage girls become infected at twice the rate of boys.

HIV disparities

In some countries, the disparity is even greater, as in Malawi and Uganda, where HIV-infected females age 15 to 19 outnumber infected males six to one. In Eastern Europe, HIV-infection rates went up sixfold between 1995 and 1997. Worldwide, 1 in 20 adolescents contracts a sexually transmitted disease every year.

In the age of AIDS, being knowledgeable about reproductive health and having control over sexual activity is a matter of life and death for young people. Both boys and girls are in jeopardy: boys because of their sexual risk-taking; girls because they generally lack the social power to set the terms of relationships, given males' traditional dominance in sexual matters.

In most encounters, the males are older, further enhancing their control. A study in Mali found that girls had their first sexual encounter at a median age of 15.8 years, compared to 20.7 years for boys. In Tanzania, female teachers had to be recruited as 'guardians' to protect young female students from the sexual advances of their male teachers. Among 53 countries reporting on marriage and cohabitation among 15- to 19-year-old males and females, every country had a higher rate for females — and in many countries it was far higher. *(See story, page 27.)*

Although the adolescent birth rate is falling in every region except sub-Saharan Africa, girls age 15 to 19 still account for more than 10 per cent of all births worldwide. One fifth of adolescents in the United States are parents before age 20, one half in Guatemala and Nicaragua and four fifths in Bangladesh.

Young women's immature bod-

Education equips girls with skills and confidence, enabling them to take their place in the world. These adolescent girls learn computer graphic design at a school in Damascus (Syria).

ies simply are not ready to have babies. Pregnancy-related deaths, mostly from obstructed labour, infection, haemorrhage, abortion and anaemia, are the leading cause of mortality for girls age 15 to 19 worldwide. The risk of death from pregnancy-related causes is four times higher in this age group than for women older than 20.

Having children when she is still a child herself interferes with a young woman's ability to make the most of her own life. Pregnancy typically ends a girl's schooling, and whatever free time she has is taken up by the demands of childcare.

Taking action

The peril is clear, but so is the potential. And it is also obvious that to take action for girls requires taking action for boys. Their lives and problems are deeply intertwined — and so must be the solutions.

Almost 10 years ago, the Convention on the Rights of the Child defined the upper age limit of childhood as 18, recognizing that adolescents are entitled to the help and protection of society. The disturbing realization that this generation is at risk has alerted governments, non-governmental organizations and individuals to some key realities: that young people as individuals have rights to information, skills and services, and that as a group they are key to the future of their nations.

Anyone who has worked with young people knows what a resource they are, especially in overcoming the problems their generation faces — among them early pregnancy, school drop-out rates, substance abuse and violence. To participate in the solutions, they need information, they need skills and services, and they need a safe and supportive environment, including trusted adults to whom they can turn for advice.

The world has begun to respond. In 1994, the international community acknowledged young people's reproductive health rights in the Programme of Action at the International Conference on Population and Development in Cairo. It said that adolescents need appropriate direction and guidance in sexual and reproductive matters in a manner consistent with their evolving maturity. Another milestone was the Fourth World Conference on Women (Beijing, 1995). It was the first international women's conference at which the Platform for Action contained a section addressing the rights of girls and young women.

These conferences have recognized that young people, girls in particular, have been denied their rights and that society has not paid attention to their needs. These gatherings have also galvanized the political commitment to address adolescent concerns. We know what works. Now we must take advantage of the political consensus to help young people cope with the social and sexual changes of adolescence.

The evidence shows that young people successfully take charge of their lives when they receive the information and learn the skills they need — and acquire the self-confidence to employ them. Numerous studies have shown, for instance, that sex education delays young people's sexual initiation or reduces the number of partners.

The media can play a role in opening minds and changing policies. Radio, television and video, magazines and newspapers, even the Internet reach into all but the most isolated corners of the developing world. These media can be used to reinforce fundamental messages, such as the fact that we *must* keep girls in school — the most cost-effective development intervention known, given the positive ripple effect of girls' education on the lives of their children and communities.

Creating a better future for adolescents also means helping them connect with others who struggle with the same questions and concerns. Young people are creating their own media initiatives to reach their peers.

Kenya's Kenyatta University has launched *KU Peer*, a student-run magazine with a nationwide circulation of 20,000, to inform young people about health issues and to recruit peer educators. The Palestinian Ministry of Youth and Sport is sponsoring a magazine produced by young people and focusing on child rights issues, with upcoming editions devoted to gender and child labour.

China's Radio Shanghai hosts a talk show called 'Whisper', which takes questions from listeners on adolescent health. Hosted by a presenter with a friendly name like 'Aunt Ling', it can be heard in almost half of China. 'Straight Talk', a radio programme run by young people to discuss youth issues including health and sexuality, airs in Kenya, Malawi, Tanzania and Uganda. The scripts for India's 'Dehleez', a popular dramatic radio serial, incorporate messages about appropriate health behaviour. Jamaica's Red Cross Peer Educator project uses a similar strategy.

But information is not enough. Young people need services, especially youth-friendly health services. In Zambia, three pilot clinics have been staffed with 52 peer educators, 16 to 26 years old, who are trained to teach negotiating skills and provide counselling on issues including HIV/AIDS, pregnancy and substance abuse. In Swaziland, an education campaign aims to motivate young people to use the services of 80 health workers specially trained in adolescent health promotion.

In an initiative in Costa Rica, young people are consulted about the health services provided, and they can take their questions to specially trained health workers. In Ukraine, the Young People's Development Programme provides youth health services as part of an effort that also aims to prevent crime, drug abuse and suicide.

While young people deal with the confusing developments of adolescence, they need education and vocational skills to enable them to support themselves. One model is a programme in Maqattam, near Cairo, that offers both literacy and vocational classes for girls — and also sends a strong message about self-worth by promising 500 Egyptian pounds ($148) to each girl who agrees to defer marriage until the age of 18 and whose marriage is consensual. Plans are under way to bring boys and men into the programme to encourage their support of girls and women, both married and single.

These initiatives are a first step towards confronting the issues that must be addressed if today's generation of young people is to reach its adult potential. These actions hold promise, but they are far too few. No country is making enough use of the institutions already in place, especially schools, religious institutions and youth clubs, to provide a safe haven for young people to work out their concerns with each other and with supportive adults.

A couple of decades ago, before the age of child rights, before the age of AIDS, adolescents in developing countries were the nearly forgotten people. But a social revolution is under way. It presents an opportunity to change the rules, to transform not only their lives but the path their nations follow in the 21st century. Young people are full of energy and ideas. It is up to us to make sure that both girls and boys have the opportunity to capitalize on their monumental potential. ■

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TEEN BIRTHS

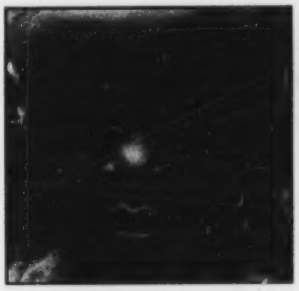
The experience of adolescent girls traditionally has been measured by examining rates of pregnancy. But focusing exclusively on reproductive health ignores other profound changes taking place during this crucial stage of life. However, in the absence of country-level statistics about the diverse forces that shape the lives of teenagers, reproductive health remains one of the only tools available to compare adolescent girls around the world.

The adolescent experience: Beyond childbearing

During the past 30 years, the time span between the age of puberty and the age of marriage and childbearing has grown, increasing the time that adolescent girls spend outside marriage. Knowing more about their lives is therefore imperative, helping both to reduce risk and to increase potential. Researchers are now beginning to study the myriad issues that arise in the lives of adolescent girls at the end of the 20th century, including:

- What is their treatment at the hands of their families? Do they eat as well as their brothers? Do they receive as much health care? How are domestic duties divided in the household? How much leisure time do girls have, and how do they spend it?
- How do they fare in school? How do their attendance rates and academic achievements compare with those of boys? Are girls treated the same as boys in the classroom? Are they encouraged to excel? Does their education influence how their families and communities perceive them?
- What is their experience in the workplace, whether formal or informal? Do they work for pay? How does their rate of pay compare to that of adolescent boys? Can they access credit? Are they slotted into traditionally female occupations?
- What is their experience with potentially risky behaviours? Do they experiment with cigarettes, alcohol, drugs? Do they engage in unsafe sexual practices? What happens when they do?

To date, answers to these questions are sketchy or anecdotal. While researchers are beginning to quantify the adolescent experience, the studies are as yet small, painting a picture of communities, rather than countries. UNICEF is working with others to create more realistic and revealing statistical indicators and is supporting governments in measuring them. As they become available, the results will be published in *The Progress of Nations*.



SUB-SAHARAN AFRICA

1	Mauritius	45
2	Burundi	54
2	Rwanda	54
4	South Africa	70
5	Botswana	83
6	Lesotho	88
7	Kenya	101
8	Namibia	104
9	Zimbabwe	114
10	Ghana	115
11	Togo	119
12	Mauritania	122
13	Mozambique	124
13	Tanzania	124
15	Eritrea	128
16	Côte d'Ivoire	131
17	Zambia	132
18	Benin	133
19	Central African Rep.	134
20	Congo	136
21	Nigeria	138
22	Cameroon	140
23	Madagascar	142
23	Senegal	142
▶	*Regional average*	*143*
25	Gambia	153
26	Burkina Faso	157
27	Malawi	159
28	Ethiopia	168
29	Chad	173
30	Gabon	175
31	Uganda	179
32	Guinea-Bissau	180
33	Mali	181
34	Sierra Leone	201
35	Congo, Dem. Rep.	206
35	Liberia	206
35	Niger	206
38	Somalia	208
39	Angola	212
40	Guinea	229

MIDDLE EAST AND NORTH AFRICA

1	Tunisia	18
2	Israel	19
3	Algeria	24
4	Lebanon	26
5	Morocco	28
6	Kuwait	31
7	Turkey	43
8	Jordan	44
8	Syria	44
10	Iraq	45
11	Sudan	52
▶	*Regional average*	*56*
12	Egypt	62
13	U. Arab Emirates	73
14	Iran	77
15	Yemen	101
16	Libya	102
17	Saudi Arabia	114
18	Oman	122

WORLD AVERAGE

Women who do not complete primary school have two to three more children on average than women with some secondary education.

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CENTRAL ASIA

1	Azerbaijan	19
2	Turkmenistan	20
3	Kazakhstan	32
4	Tajikistan	33
5	Uzbekistan	35
6	Kyrgyzstan	40
7	Armenia	41
8	Georgia	46
▶	*Regional average*	*59*
9	Afghanistan	152

EAST/SOUTH ASIA AND PACIFIC

1	Japan	4
1	Korea, Rep.	4
3	China	5
3	Korea, Dem.	5
5	Singapore	8
6	Cambodia	15
7	Sri Lanka	20
8	Australia	22
9	Papua New Guinea	24
10	Malaysia	26
11	Myanmar	31
12	New Zealand	32
13	Viet Nam	33
14	Mongolia	39
15	Philippines	40
16	Lao Rep.	50
▶	*Regional average*	*56*
17	Indonesia	58
18	Thailand	70
19	Bhutan	84
20	Nepal	89
20	Pakistan	89
22	India	109
23	Bangladesh	115

AMERICAS

1	Canada	24
2	Chile	49
3	Trinidad/Tobago	51
4	Haiti	53
5	Peru	57
6	United States	60
6	Uruguay	60
8	Argentina	64
9	Cuba	65
▶	*Regional average*	*68*
10	Mexico	69
11	Brazil	71
11	Ecuador	71
13	Colombia	74
14	Paraguay	76
15	Bolivia	79
16	Panama	81
17	Dominican Rep.	88
17	Jamaica	88
19	Costa Rica	89
20	El Salvador	92
21	Venezuela	98
22	Guatemala	111
23	Honduras	113
24	Nicaragua	133

EUROPE

1	Switzerland	4
2	Netherlands	7
3	France	8
3	Italy	8
5	Belgium	9
5	Denmark	9
7	Spain	10
7	Sweden	10
9	Finland	11
10	Germany	13
11	Ireland	14
12	Norway	16
13	Greece	18
14	Austria	21
15	Lithuania	22
15	Portugal	22
17	Belarus	24
18	Poland	25
▶	*Regional average*	*25*
19	Estonia	27
19	Slovenia	27
21	Bosnia/Herzegovina	29
21	Hungary	29
23	Latvia	30
24	Albania	31
24	Croatia	31
24	United Kingdom	31
27	Moldova, Rep.	32
28	Czech Rep.	35
28	Slovakia	35
30	Ukraine	36
31	Yugoslavia	38
32	Russian Fed.	39
33	TFYR Macedonia*	40
34	Romania	43
35	Bulgaria	57

WHAT THE TABLE RANKS

Births per 1,000 females age 15–19

* The former Yugoslav Republic of Macedonia, subsequently referred to as TFYR Macedonia.

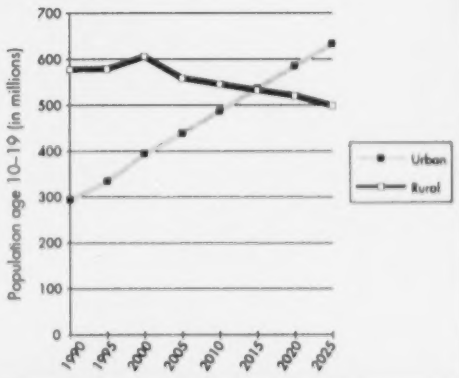
Source: UN Population Division, Dept. of Economic and Social Information and Policy Analysis, *World Population Prospects: The 1996 Revision*, New York, 1997.

Moving to the cities

Adolescent population in developing countries by urban and rural areas, 1990–2025

The largest generation in history will soon be the most urbanized. Moving to the city may mean:

- Growing exposure to risks — alcohol and drugs, violence, risky sexual practices, HIV/AIDS.
- Loss of culture and isolation from extended family.
- Improved access to better schools, youth-friendly health services (if subsidized).
- More employment opportunities.
- Falling birth rates (over time).



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Women's health: Up in smoke?

Smoking among women in developing countries is far less prevalent than among men — so far. WHO estimates that 48% of males aged 15 and over in the developing world smoke, compared to only 7% of females. But in developing countries, with fewer restrictions to stop the tobacco companies' aggressive marketing and with less public awareness of smoking's grave risks, it is only a matter of time before the percentage of women smokers starts to climb. Stemming a surge in smoking among girls and women is therefore a global health challenge.

Among 87 countries with available data, there are 38 countries worldwide where 20% or more women age 15 or older smoke. Only 7 of these are developing countries: Brazil, Chile, Cook Islands, Cuba, Fiji, Papua New Guinea and Uruguay. The highest women's smoking rates are in Europe — Denmark and Norway top the list with 37% and 36%, respectively.

About 3.5 million people die each year from tobacco use, more than half a million of them women. As the proportion of women smokers increases, so ultimately will the proportion of women dying from tobacco-related causes.

Most smokers start during their teens — the median age of initiation is under 15 in many countries. In a number of industrialized countries, including Austria, Denmark, Spain and Sweden, smoking rates are now higher among teenage girls than teenage boys, according to WHO. Yet the tragic impact in illness and death among these young people will not appear in the statistics for about 30 years. In the industrialized countries where women have long smoked, their death rate from smoking-related disease is rising rapidly, accounting for 25% to 30% of all female deaths in middle age.

In addition to the main smoking-related illnesses, including lung and oral cancer, emphysema and heart disease, women smokers face increased risk of cervical cancer, impaired fertility and premature menopause. There is also a higher rate of miscarriage among expectant mothers who smoke, and smoking during pregnancy is linked to low birth weight, which increases infants' risk of death and illness.

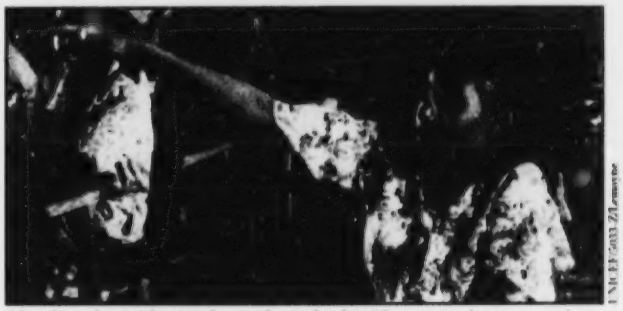
The Convention on the Rights of the Child mandates countries to safeguard children's health and to protect them from exploitation and promote health education. Therefore, support for strong restrictions on the sale and promotion of tobacco products to children and teens is a global child rights issue.

Where 20% or more women smoke

Percentage of smokers aged 15 or above

Country	Men	Women
Denmark	37	37
Norway	36	36
Czech Rep.	43	31
Fiji	59	31
Israel	45	30
Russian Fed.	67	30
Canada	31	29
Netherlands	36	29
Poland	51	29
Greece	46	28
Iceland	31	28
Ireland	29	28
Papua New Guinea	46	28
Austria	42	27
France	40	27
Hungary	40	27
Uruguay	41	27
Cook Islands	44	26
Italy	38	26
Luxembourg	32	26
Slovakia	43	26
Switzerland	36	26
United Kingdom	28	26
Brazil	40	25
Chile	38	25
Cuba	49	25
Spain	48	25
Estonia	52	24
Sweden	22	24
Turkey	63	24
United States	28	24
Argentina	40	23
Slovenia	35	23
Germany	37	22
New Zealand	24	22
Australia	29	21
Bolivia	50	21
Costa Rica	35	20

Source: WHO, *The Tobacco Epidemic: A Global Public Health Emergency*, table 3, April 1996.



More boys than girls attend secondary school in 25 countries, but rates are low for both in sub-Saharan Africa. This adolescent girl attends school in Ethiopia.

Girls missing in secondary school classrooms

Primary school enrolment rates have risen all over the world in recent decades, and the gender gap in primary education is beginning to close. But, when it comes to secondary education, it is a different story.

In 25 countries the proportion of boys enrolling in secondary school is higher than girls by 10% or more, and in five — India, Nepal, Togo, Turkey and Yemen — the gap exceeds 20%. In more than 40 countries worldwide, fewer than 25% of girls are enrolled in secondary school.

The worst disparity is found in South Asia, where 52% of boys but only 33% of girls enrol — a gap of 19%. Secondary enrolment is low for both boys and girls in sub-Saharan Africa, with rates of just 27% and 22%, respectively, but nonetheless, girls trail behind.

In contrast, 13 countries have higher enrolment rates for girls than boys by 10% or more. Girls generally lead boys in Latin America and the Caribbean, with 56% of girls and 52% of boys enrolled in secondary school.

School enrolment

Countries with large disparities between boys' and girls' secondary school enrolment...

	...where ratio is higher for boys than girls by 10% or more*
Cameroon	10
Zimbabwe	10
Chad	11
Morocco	11
Egypt	12
Guinea	12
Lao People's Dem. Rep.	12
Uzbekistan	12
Benin	13
Congo, Dem. Rep.	13
Gambia	13
Zambia	13
Bangladesh	14
Cambodia	14
Iran	14
Côte d'Ivoire	15
Ghana	16
Pakistan	16
Congo	17
Iraq	19
India	21
Turkey	22
Nepal	24
Togo	27
Yemen	28

	...where ratio is higher for girls than boys by 10% or more*
Colombia	10
Namibia	10
Spain	11
Lesotho	12
Venezuela	12
Dominican Republic	13
Trinidad and Tobago	13
South Africa	15
Uruguay	15
Finland	16**
Guyana	17
Mongolia	18
United Kingdom	22**

* Includes all students enrolled in secondary school regardless of age.

** Disparity due to higher enrolment in secondary vocational schools for young women age 20 and older.

Source: *UNESCO Statistical Yearbook 1997*. (Data: 1990–95.)

Too many teen brides

Teenage marriage may be less common than it was a generation ago, but in many countries, and for many young women, it is still the norm. Compared to girls who marry later, teenage brides typically have less schooling, less independence and less experience of life and work. Boys, in contrast, rarely marry during their teens.

A young girl often does not have a say in whether and whom she will marry, and she is frequently subordinate to her older partner in fundamental family decisions, such as when to have children and how many to have. The age difference between a teenage married woman and her partner further exacerbates the disparities in power. Early marriage is closely linked to early, repeated and unplanned childbearing. Death rates are higher for both mothers and babies, as teenage bodies are not ready for the rigours of pregnancy or childbirth.

Data from 53 countries show that the highest rates of 15- to 19-year-old girls 'in union'— either married or cohabiting — are in sub-Saharan Africa, followed by Asia. Among the 22 countries in sub-Saharan Africa with data, more than 25% of girls in this age-group in 14 countries are married or cohabiting. Five countries have rates above 40%. The data include diverse types of union socially accepted in various societies, including marriage, forms of cohabitation and polygyny, in which a man has more than one wife at a time.

The contrast in the rates of marriage between teen girls and boys is considerable in most countries. All countries reporting have higher rates of teen marriage for girls, and in only two do teenage boys' rate of marriage or cohabiting exceed 10%.

Although delaying marriage until after adolescence has many advantages, there are also risks. Unmarried teenage girls who are sexually active face the risk of unintended pregnancy, as well as sexually transmitted diseases, including HIV/AIDS.

Married adolescents

Per cent of 15- to 19-year-olds who are currently married or cohabiting

Sub-Saharan Africa	Males	Females
Mali	1	72
Niger	14	57
Uganda	8	47
Burkina Faso	3	44
Cameroon	3	41
Central African Rep.	6	39
Nigeria	–	37
Malawi	6	36
Liberia	3	32
Senegal	1	29
Togo	2	27
Zambia	2	27
Côte d'Ivoire	3	26
Tanzania	3	26
Madagascar	9	21
Ghana	2	20
Zimbabwe	2	19
Kenya	3	15
Rwanda	3	8
Namibia	–	7
Botswana	1	6
Burundi	4	6
Middle East and North Africa		
Yemen	13	24
Sudan	3	15
Egypt	3	14
Turkey	5	13
Morocco	2	12
Tunisia	0	4
Asia		
Bangladesh	7	48
India	6	38
Pakistan	4	24
Indonesia	2	17
Thailand	4	16
Philippines	4	7
Sri Lanka	1	7
China	1	3
Latin America and Caribbean		
El Salvador	4	24
Guatemala	8	24
Trinidad/Tobago	1	20
Dominican Rep.	6	18
Mexico	7	18
Ecuador	4	17
Bolivia	3	15
Brazil	2	14
Colombia	6	14
Paraguay	1	14
Peru	3	10
Industrialized countries		
United Kingdom	3	11
Poland	1	8
United States	1	8
France	1	4
Germany	0	2
Japan	0	2

Source: The Alan Guttmacher Institute, *Into a New World: Young Women's Sexual and Reproductive Lives*, New York, 1998. (Data: 1986–96.)

The family planning gap

For any girl, married or unmarried, few events are as traumatic as an unwanted pregnancy. Nonetheless, a significant number of adolescent girls aged 15 to 19 are sexually active and do not want a child, but are not using any form of family planning, according to a recent survey.

In more than half of the 46 countries providing data, which are home to almost 50% of the world's population, at least 10% of girls aged 15 to 19 have an unmet need for family planning services. The data do not reveal whether family planning services are actually available or whether it is legal for adolescents under 18 to obtain them. The highest rates are found in sub-Saharan Africa, where 20% or more of adolescent girls use no means of contraception in 10 of the 21 countries surveyed, and where many sexually active girls are also unmarried. This is also the case in the United States, the only industrialized country covered, where 9% of unmarried girls aged 15 to 19 have an unmet need for family planning, compared to only 1% of married girls. Unmarried pregnant adolescents face larger risks, including the possibility of receiving less care and of family rejection.

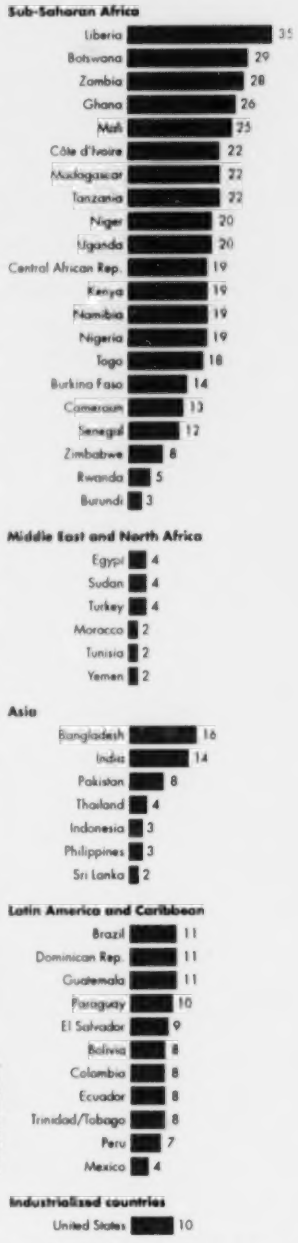
Postponing marriage and childbearing gives girls the chance for more education and experience and for improving their own health, nutrition and well-being and that of their future children.

UNICEF/Chiolero

Significant numbers of 15- to 19-year-old girls do not use or have access to family planning services. An adolescent mother watches over her premature baby in a hospital in Encarnación (Paraguay).

Unmet need

Per cent of women aged 15–19 who are sexually active, do not want a child soon and are not using any method of contraception



Source: The Alan Guttmacher Institute, *Into a New World: Young Women's Sexual and Reproductive Lives*, New York, 1998.

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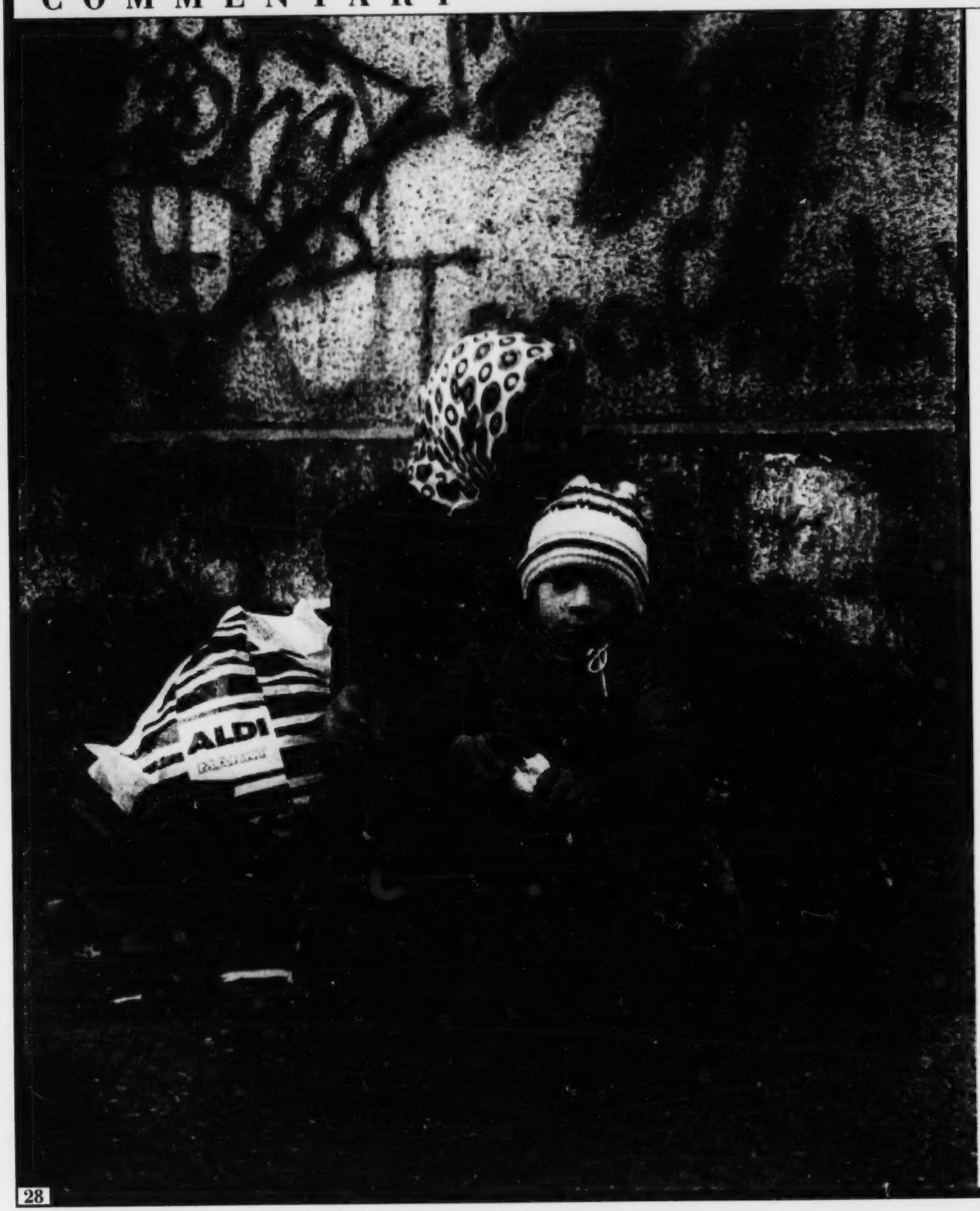

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Hardship in the midst of plenty

Philip Alston

Throughout history, homelessness has been a haunting human fear. In every century, disasters, whether the result of human actions or of nature, have left behind troops of wanderers: men, women and children with no space to claim as their own. While it might be tempting to assume that homelessness is tied to a specific catastrophic event such as war or famine, today it is a stark reality in some of the world's wealthiest countries.

Many people living in the industrialized world have no place to sleep tonight, had no place last night and will have no place tomorrow night. In their dozens or hundreds or thousands, they drift along the streets of large, prosperous cities, often with babies in their arms, seeking warmth, safety and stability that are increasingly hard for them to find.

Several studies show the extent of the homelessness problem. For example, it is estimated that there are about 3 million people in the 15 countries of the European Union who do not have a permanent home. While Germany does not survey homelessness, a non-governmental organization estimated that more than 850,000 people were homeless in the country, of whom only a third were immigrants.

However, the problem is not limited to the European Union: On any given night, three quarters of a million people in the United States are homeless; in Toronto, Canada's largest city, 6,500 people stayed in emergency shelters on a typical night in late 1997, a two-thirds increase in just one year.

Because they are, on average, poorer than men, women can wind up on the streets. If she is on her own, if she heads a family or is trying desperately to escape from violence and abuse in her own home, a woman faces especially grim prospects. For example, it is estimated that in the United Kingdom, almost half of working women do not earn enough to afford the rent on even a one-bedroom unit. In the United States, women head about one third of all families, but half of all impoverished families.

Furthermore, an 11-city survey carried out in the United States shows that, on average, the fair market rent for a two-bedroom apartment would require hourly wages of $10.73 — more than twice the current minimum wage of $5.15 — assuming one third of income is allocated to rent. And it is women who are over-represented in precisely the low-status, service-sector jobs that pay minimum wage.

While there are few statistics on the homeless — in census-taking they often, quite literally, don't count — many of the documented homeless are children, including the very young. In the United States in 1996, 5.5 million children were living in poverty, and it is reasonable to surmise that a goodly number of them were relegated to the streets.

The German study referred to earlier showed that a third of the homeless were children or adolescents, while estimates suggest that almost 250,000 young people between 16 and 24 became homeless in the United Kingdom within a single year, 1995.

In Australia, an estimated 21,000 young people between the ages of 12 and 18 are homeless at any one time.

And in the past 20 years, in many industrialized countries, the number of single-parent, especially mother-led, families has increased, with a large percentage living below the poverty line, particularly in Australia, Canada and the United States.

According to article 27 of the Convention on the Rights of the Child, "States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development." By its nature, homelessness denies every one of those rights.

Homeless young people are twice as likely as others to suffer from such chronic diseases as respiratory or ear infections, gastrointestinal disorders and sexually transmitted diseases, including HIV/AIDS. In the United States, a homeless girl in her early teens is 14 times more likely to become pregnant than a girl with a home. In Belgium, half of the homeless people in shelters had dropped out of school during or immediately after primary school. In Germany, 8 of 10 homeless people living in shelters completed only primary education or had no schooling at all, while in Luxembourg, the figure is 9 out of 10.

Rather than enjoying the right to "a standard of living adequate for the child's physical, mental, spiritual, moral and social development," children on the street suffer from the cumulative effects of poverty, hunger, family breakdown, social isolation and, very often, violence and abuse. On their own before they have the opportunity to develop personal identities or to mature, without

Philip Alston has served since 1991 as Chairperson of the UN Committee on Economic, Social and Cultural Rights. Mr. Alston is also Chairperson of the Meeting of Chairpersons of the six UN expert bodies responsible for supervising the major human rights treaties. In addition, he is Director of a major project to draft a proposed Human Rights Agenda for the European Union for the New Millennium. Mr. Alston is Professor of International Law and Head of the Law Department at the European University Institute in Florence (Italy).

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the stability required for self-confidence, or the skills and education needed to cope in the world, they are immensely vulnerable to enticement into prostitution, drug use and various forms of criminal behaviour. Sometimes, these are the only ways they can hope to survive. Moreover, often lacking experience with trustworthy adults, teenagers on their own can perceive offers of help as attempts to capture and hold them, and they may reject the very services they need most.

Many see only one way out: A 1995 national study in the United States found that 26 per cent of young people in emergency shelters and 32 per cent of those on the street had made at least one suicide attempt.

All this is happening at the same time that the industrialized world has been reaching dazzling levels of economic prosperity: The per capita gross national product of 12 industrialized countries more than doubled between just 1980 and 1995.

Within industrialized countries, there are increasing concentrations of wealth and want, as economies split between well-educated, highly paid professionals and entrepreneurs, and the socially, politically and economically disenfranchised. The latter are then seen as victims of 'collateral damage', the unfortunate but inevitable consequence of a vast array of fundamental shifts in the workplace. Many well-paid, full-time, secure and rewarding jobs, especially in manufacturing, have disappeared. Increased reliance on part-time, temporary workers has undermined family and community stability.

That instability mirrors and weakens already shifting family structures: More families must depend on two earners in order to maintain themselves at even a sustenance level.

At the same time, the demonization of caring government — a phenomenon that has been particularly pronounced in countries like Australia, Canada, New Zealand, the United Kingdom and the United States — leads to declining public investment in social housing and in local authorities and non-profit organizations concerned about the issue. This has been accompanied by a parallel demonization of the poor themselves — with women who receive welfare cheques dismissed as 'welfare queens' — which makes it easier for communities to cut funds and programmes designed to assist the most fragile of its members.

Excluding the poor

Homelessness is the predictable result of private and public-sector policies that exclude the poor from participating in the economic revolution, while safety nets are slashed in the name of 'global competitiveness'. Moreover, the situation is perpetuated by a deep reluctance to tackle the roots of the problem.

Such concepts as the existence of a social contract, of community, of concern for the long-term good or even of public morality are discarded as people ignore the growing, simultaneous presence of high levels of prosperity on the one hand and of homelessness on the other. The principles of economic and social rights — an integral part of the Universal Declaration of Human Rights, the 50th anniversary of which is being celebrated with much fanfare — are trampled without regard or regret.

That lack of a collective conscience makes it possible — at a time when the booming economy and deregulation of the private sector have led to soaring rents — for the United Kingdom and other countries to sell off public housing, either to occupants or to private landlords, without regard to the need for substitute measures for those who remain or are being added to the lists of the homeless.

Despite bureaucratic assurances that there are satisfactory stocks of 'affordable housing', flourishing real estate markets have led to gentrification of entire neighbourhoods that once offered low-cost shelter to poor people. Because the number of workers who are either unemployed, underemployed or low paid has grown, more and more people have to rely on shrinking social welfare payments. In many countries, it is the young who, once more, are specially targeted. For example, since 1988, 16- and 17-year-olds in the United Kingdom have been denied welfare, which is a factor in the rising number of homeless young people in that country.

Mental illness, drugs, and alcohol abuse continue to destroy lives, but fewer resources are being invested in dealing with them. In the United States, institutions for the mentally ill have been closed in favour of more humane community living arrangements, but these are chronically underfunded. Eager to live with others, but often without adequate back-up services and support, many such people are left to fend for themselves on the streets.

People in the industrialized world are living with the results of the changes that have occurred and of our responses (or lack of responses) to them. In Greece, Ireland, Italy, Luxembourg, Portugal and Spain, the number of households in which people live below the poverty line now far exceeds the number of available social housing units. In Spain, for example, 2 million households that would qualify for social housing are competing for just 200,000 units. In Greece, where members of 650,000 households live in poverty, there is no social housing.

While it is becoming easier to fall from a marginal (and even a managerial) job to the street, it is much harder — virtually impossible — to make the journey in the other direction. There are daunting obstacles: the lack of a permanent address, a place to keep clean, the carfare required for a job search, a telephone number to leave with prospective employers. Now, the barriers are being raised higher still as governments cut back on assistance, tie it to work (or make-work) projects, insist that women with small children go into the workforce (although safe and adequate day care may not be available) and deny more categories of applicants. This identical pattern may not, of course, be true everywhere — in the Nordic countries, for example — but it is sufficiently repetitive as to seem pervasive.

In their zeal to deny the evidence of economic or social malfunctioning, more and more communities have tended to criminalize homelessness, a move that is, in equal parts, cynical and futile. By the end of 1996, three quarters of the 50 largest cities in the United States had imposed anti-begging laws. In Seattle, officials ordered vigorous enforcement of sidewalk and trespass laws, making it difficult for homeless people even to sit on benches in the downtown area. Like their rights, their existence is denied.

It is easy enough to ascribe 'rights' to people, including the right to housing. Fifty years ago, the Universal Declaration of Human Rights proclaimed that every person has the right to "... a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing ..." Since then, 11 additional human rights instruments have enshrined the right to decent housing.

Actually achieving those rights is, of course, more problematic. Even last-resort housing, emergency shelter, is in short supply. For example, although the number of shelter beds in Los

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Homelessness interferes with the fulfilment of rights and with normal family life. This family of five, having reached the maximum stay in a shelter, has been given a one-week voucher for a motel room in Daytona Beach (USA). The children, ages 7 to 13, are not in school.

Angeles more than tripled, from 3,500 to 10,800, between 1986 and 1996, there are still five to eight homeless people for every available space.

Delegates to the Second United Nations Conference on Human Settlements (Habitat II, Istanbul, 1996) and those to the World Food Summit (Rome, 1996) laboured long and hard to win grudging endorsements of the rights to housing and to food, respectively. Throughout most of the industrialized world, the right to housing is treated as nothing more than the statement of a worthy, albeit distant, goal. Perhaps the problem is one of perception: that the enshrined right to housing would mean committing to massive home-building programmes and then to the cost of maintaining such housing stocks.

In reality, however, what is needed most is a determination to create *conditions* that promote housing opportunities for all. That means removing obstacles to housing, including the gap between the minimum wage and the cost of decent accommodation, as well as establishing partnerships with homeless people, service and support groups, communities and local governments. Unfortunately, the private sector, which is so often a source of innovative solutions, has not shown any sustained interest in tackling the problem, which it does not see as part of its responsibility. Now, however, the private sector must somehow become involved in creating affordable housing, acknowledging that a healthy future for children depends on many things, housing among the most important of them.

Failure to take those steps dooms countries to continuing crises of homelessness. Under the McKinney Act, the United States has spent more than $10 billion on assistance for the homeless. In addition to emergency food, shelter and health care, it has financed help for young runaways, for initiatives designed to aid homeless people in making their way back into the housing market and for placing homeless children in school.

Throughout the years, the Act, which came into force in 1987, has undoubtedly helped hundreds of thousands of Americans move out of the legions of the homeless. But the tendency to 'put out fires', to respond to symptoms of homelessness rather than treating its roots, means that the numbers continue to rise.

Nonetheless, there are some reasons for cautious optimism. There are a number of industrialized countries, especially in Europe, that are ever more imaginative in seeking solutions. In Belgium, Finland, the Netherlands, Portugal and Spain, the right to housing has been incorporated into the national constitutions. While this often amounts only to a statement of intent rather than an entitlement, it is a sign that attitudes to homelessness are slowly becoming more humane and realistic. Other countries need to follow suit by giving a more sustained and practical emphasis to adequate housing as a human right.

A number of cities in Belgium now tax uninhabited houses in order to discourage owners from neglecting property and speculating. In the city of Ghent, that particular initiative led to a 50 per cent decrease in the number of registered uninhabited homes in just five years. France has announced an ambitious programme of building houses for the extremely disadvantaged and requisitioning vacant houses from institutional owners.

Austria's Special Assistance Bureau for Persons in Danger of Eviction offers a service to help people organize their finances. As a result, 60 per cent of rental arrears are eventually paid by tenants, and evictions, which are costly to taxpayers, are prevented.

Perhaps the most concerted and successful effort to deal with homelessness is in Finland where, after the International Year of Shelter for the Homeless in 1987, the Government devised a multifaceted response to the problem. It includes house-building, social welfare and health care services, and the obligation to provide a home of minimum standards for every homeless person. In just 10 years, the number of homeless in Finland has been cut in half.

As part of its attack on the problem, Finnish authorities recognized that the homeless young, in particular, need more than four walls and a roof. Therefore, they established a programme for housing homeless teenagers near 'support families' who help them keep their lives on track.

Clearly, homelessness is not an unsolvable problem if we have the political will to remove the strangling obstacles and to apply imaginative solutions.

Celebrations of a new millennium will ring hollow, indeed, if we do not put in place new plans, new ideas and a new determination to eliminate the homelessness that has bedevilled human history. Early in this century John Dewey, the great American educator, described what the goal should be. It remains as hopeful, and as distant, as it was then: "What the best and wisest parent wants for his [or her] own child, that must the community want for all its children." ■

Child death rates plummet

Death rates of children and youth in industrialized countries are low, and one might think there is little room for improvement. Yet mortality rates among children under 20 in industrialized countries have fallen dramatically in recent decades. Death rates for girls and boys in 1993 are less than half what they were in 1970.

Nonetheless, boys continue to die, on average, at a rate about 50% higher than girls: Boys' rates fell from 184 per 100,000 in 1970 to 84 in 1993, while girls' declined during the same period from 126 per 100,000 to 57. Boys die at higher rates than girls in all industrialized countries.

The disparity in boys' and girls' death rates is highest in Portugal, where the rate for boys in 1993 was 72% higher than for girls. Israel has the smallest disparity, with the boys' rate 25% greater.

There are significant disparities among countries. Romania has the highest combined mortality rates: 179 deaths per 100,000 population for boys and 127 per 100,000 for girls. Japan has the lowest rates: 54 deaths per 100,000 for boys and 35 for girls.

Most of the decline in death rates among under-20s occurred among children under 5, mainly the result of improved health care. Death rates for ages 15–19 (boys and girls) declined by about half the under-5 rate. Most of the older boys' deaths are caused by accidents, such as car crashes, falls and firearm mishaps.

Boys' death rates surpassing girls'

	Deaths per 100,000 population age 0–19, 1993		% decline in mortality rate, 1970–93		% by which male rate exceeds female rate
	Male	Female	Male	Female	1993
Israel	80	64	–	–	25
Greece	71	51	69	72	39
Sweden	57	41	52	48	39
Netherlands	66	47	53	50	40
Bulgaria	137	97	45	46	41
Hungary	106	75	61	62	41
Romania	179	127	60	65	41
United Kingdom	68	48	60	60	42
Germany	65	45	–	–	44
Switzerland	69	48	58	56	44
Denmark	71	49	51	47	45
Poland	113	78	52	54	45
Australia	73	49	61	62	49
Canada	73	49	57	57	49
United States	104	69	45	45	51
New Zealand	102	67	45	46	52
Finland	61	40	56	54	53
France	72	47	56	58	53
Japan	54	35	67	68	54
Spain	71	46	–	–	54
Austria	82	53	65	66	55
Norway	70	45	53	51	56
Czech Rep.	90	57	–	–	58
Russian Fed.	181	110	–	–	65
Portugal	115	67	–	–	72

Source: UNICEF, based on data from WHO

Getting the lead out

Lead poisoning has serious health consequences, especially for children, and there is no easy cure. The good news is that industrialized countries are succeeding in efforts to reduce lead exposure, resulting in lower levels of lead in the blood of both children and adults.

The United States has the largest reduction in blood lead levels among the 11 countries for which data are available, with an 82% reduction over 15 years. Canada, Italy and Sweden follow. Much of this progress is due to the reduction of lead in gasoline, but removing lead from other sources, especially the solder in food cans, has also helped. The US Environmental Protection Agency (EPA) reports that elimination of leaded gasoline saves the United States more than $400 million a year in children's health care costs.

Lead can damage a child's brain, kidneys and reproductive system, and at high levels of exposure can cause coma, convulsions and death. Even low levels are associated with reductions in IQ and attention span, learning disabilities, hyperactivity, behavioural problems, impaired growth and hearing loss.

Major sources of lead include leaded gasoline, paint, water pipes, food-can solder, ceramic glazes, cosmetics, patent medicines and lead-acid batteries, as well as factory emissions.

Over the past years, as evidence has mounted of lead toxicity at even low concentrations in the blood, medical authorities have repeatedly reduced the blood lead level deemed acceptable, and countries have taken steps to reduce exposure. In 1991, the United States set the 'level of concern' for lead in the blood of children at 10 micrograms per decilitre, and other countries have adopted this standard. However, no clearly defined safe threshold has been found.

The success of the industrialized countries in reducing lead exposure points to the need for global action, since children tested in developing countries have been found much more likely to carry high concentrations of lead in their blood.

Falling lead levels

Sources: Fanelli, James J., *An analysis of worldwide studies detailing the effects of the reduction of gasoline lead on air lead and blood lead*, Center for Energy and Environmental Studies, Princeton University, 1997; and Centers for Disease Control and Prevention, 'Update: Blood lead levels – United States, 1991–94', *Mortality and Morbidity Weekly Report*, vol. 46, no. 7, 1997.

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Aid should target people's basic needs, such as water and sanitation. Here, two girls use a handpump in a village near Asyut (Egypt).

Targeting poverty

In the battle against poverty, basic social services are fundamental. This means securing people's access to education, health care, adequate nutrition, family planning services, and safe water and sanitation.

UNICEF and other development agencies promote the 20/20 Initiative, which calls on governments of donor and developing countries to allot 20% of their development assistance and national budgets, respectively, to basic services.

Donor countries are becoming more explicit and transparent in reporting on their support for basic services. In the past three years, annual reports on aid by the Organisation for Economic Co-operation and Development (OECD) have included data on bilateral (or country-to-country) aid to basic education and health. All but 5 of 21 donors provided data on at least one of these categories in the latest report.

Among countries providing data in 1995, the United States gave the highest portion of bilateral aid to basic health care: 5.3%. Germany provided 4.0% of its bilateral aid for basic education, the highest among countries reporting. These are disappointing figures compared to the target of 20%.

Aid to the basics

	% of total aid (1995) committed to:	
	Basic education	Basic health
United States	1.8	5.3
Sweden	3.1	5.0
Australia	2.6	3.7
Belgium	0.3	3.6
Norway	1.1	3.5
Canada	0.1	3.1
Spain	0.9	3.0
Netherlands	1.2	2.9
Germany	4.0	1.4
Italy	–	1.4
Finland	–	0.9
New Zealand	0.1	0.7
Japan	0.5	0.6
Switzerland	0.4	0.5
Austria	–	0.4
Portugal	0.1	0.4
Denmark	–	–
France	–	–
Ireland	–	–
Luxembourg	–	–
United Kingdom	–	–
Total	**1.2**	**1.7**

Source: OECD, Development Co-operation (1997 report), 1998.

Is aid heading for extinction?

For the fifth straight year, aid for development provided by industrialized countries has declined, slipping to $55.5 billion in 1996, a decrease of 4% in real terms from 1995 and down by 16% from the highest aid level, in 1992. In fact, at the present rate of decline, official development assistance (ODA) would cease to exist by 2015.

This trend jeopardizes a commitment by donor countries to close gaps between the 'haves' and the 'have nots' within and between countries. Donor countries pledged to achieve by 2015 a 50% reduction in the number of people, currently 1.3 billion, living in absolute poverty — on a dollar a day or less.

ODA as a proportion of donor countries' GNPs, a measure of their ability to provide aid, fell to an average of 0.25% in 1996, compared to 0.34% in 1990. That is the lowest proportion since 1970, when the aid target of 0.7% of donors' GNPs was agreed upon.

Only four countries — Denmark, the Netherlands, Norway and Sweden — consistently allocate more than the target. Denmark topped the list in 1996, allotting 1.05% of its GNP for aid, while the United States ranked lowest, giving 0.12%.

Denmark also led donors on the basis of aid per person, giving $338 per capita, while Portugal was the lowest per capita donor at $22. Japan and the United States were the largest donors in total dollar terms, each allocating $9.4 billion.

If all donors had met the aid target, annual ODA would be $100 billion above its current level. That amount, over 10 years, would be more than sufficient to ensure that everyone in developing countries had access to basic social services — including basic education, health care, family planning, adequate nutrition and safe water and sanitation.

Aid: Going, going . . .

	ODA as % of donor nations' GNP		Amounts (in 1996 $)		
	%1996	%1990	Total aid ($ billions) 1996	Aid per person ($) 1996	Change per person ($) since 1990
Denmark	1.05	1.03	1.8	338	66
Sweden	0.88	0.99	2.0	227	-23
Norway	0.87	1.23	1.3	302	-9
Netherlands	0.80	0.98	3.2	208	1
France	0.49	0.65	7.5	128	-26
Luxembourg	0.44	0.23	0.1	199	106
Belgium	0.34	0.57	0.9	90	-24
Finland	0.34	0.65	0.4	80	-79
Canada	0.32	0.43	1.8	60	-22
Germany	0.32	0.36	7.6	93	-8
Switzerland	0.32	0.34	1.0	142	2
Australia	0.31	0.33	1.1	62	-1
Ireland	0.29	0.17	0.2	50	33
United Kingdom	0.28	0.28	3.2	55	6
Austria	0.24	0.27	0.6	69	3
New Zealand	0.22	0.22	0.1	34	-2
Portugal	0.22	0.31	0.2	22	0
Spain	0.22	0.22	1.3	32	5
Italy	0.21	0.35	2.4	42	-20
Japan	0.18	0.29	9.4	75	-26
United States	0.12	0.21	9.4	35	-17
Average	**0.25**	**0.34**	**Total $55.5**	**Avg. $68**	**-$15**

Source: OECD, Development Co-operation (1997 report), 1998.

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Target 2000

A summary of the year 2000 goals agreed to by almost all nations at the 1990 World Summit for Children.

1. Reduction of infant and under-5 child mortality rates by one third of the 1990 levels, or to 50 and 70 per 1,000 live births respectively, whichever is less.

2. Reduction of the 1990 maternal mortality rates by half.

3. Reduction of severe and moderate malnutrition among under-5 children by half of the 1990 levels.

4. Universal access to safe drinking water and to sanitary means of excreta disposal.

5. Universal access to basic education and completion of primary education by at least 80% of primary-school-age children.

6. Reduction of the adult illiteracy rate (the appropriate age group to be determined in each country) to no more than half its 1990 level, with emphasis on female literacy.

7. Improved protection of children in especially difficult circumstances.

	Total population (millions) 1996	Population under 18 (millions) 1996	Annual no. of births (thousands) 1996	Annual no. of under-5 deaths (thousands) 1996	Under-5 mortality rate 1996	GNP per capita ($) 1996	% of under-5 children under-weight 1987–97	Net primary school enrolment/ attendance [a/] (%) 1987–97	Total fertility rate 1996	Maternal mortality rate [b/] 1990
SUB-SAHARAN AFRICA										
Angola	11.2	6.0	546	159	292	270	–	–	6.8	1500
Benin	5.6	3.1	238	40	169	350	29	43 y	6.0	990
Botswana	1.5	0.7	52	3	50	3020	15	96	4.6	250
Burkina Faso	10.8	5.8	501	87	173	230	30	33 y	6.7	930
Burundi	6.2	3.3	272	48	176	170	37	52	6.4	1300
Cameroon	13.6	6.9	539	55	102	610	14	65 y	5.4	550
Central African Rep.	3.3	1.6	127	22	173	310	27	63 y	5.1	700
Chad	6.5	3.2	275	54	198	160	–	41	5.6	1500
Congo	2.7	1.4	115	12	108	670	17	–	6.0	890
Congo, Dem. Rep.	46.8	25.1	2135	442	207	130	34	56 y	6.4	870
Côte d'Ivoire	14.0	7.2	523	78	150	660	24	53 y	5.3	810
Eritrea	3.3	1.7	135	16	120	100	44	31	5.5	1400
Ethiopia	58.2	30.6	2856	506	177	100	48	24	7.0	1400
Gabon	1.1	0.5	41	6	145	3950	–	86 y	5.3	500
Gambia	1.1	0.5	46	4	92	320	21	47 y	5.3	1100
Ghana	17.8	9.1	692	76	110	360	27	70 y	5.4	740
Guinea	7.5	4.0	359	75	210	560	26	33 y	6.7	1600
Guinea-Bissau	1.1	0.5	44	10	223	250	–	45	5.5	910
Kenya	27.8	14.7	1027	92	90	320	23	84 y	5.0	650
Lesotho	2.1	1.0	74	10	139	660	16	75 y	5.0	610
Liberia	2.2	1.1	121	28	235	490	–	56 y	6.5	560
Madagascar	15.4	8.2	643	105	164	250	34	62 y	5.8	490
Malawi	9.8	5.3	487	106	217	180	30	83 y	6.8	560
Mali	11.1	6.0	539	130	241	240	27	41 y	6.8	1200
Mauritania	2.3	1.2	90	16	183	470	23	54 y	5.1	930
Mauritius	1.1	0.4	22	1	23	3710	16	96	2.3	120
Mozambique	17.8	9.1	763	163	214	80	27	40	6.2	1500
Namibia	1.6	0.8	57	4	77	2250	26	92	5.0	370
Niger	9.5	5.2	484	155	320	200	43	26 y	7.2	1200
Nigeria	115.0	59.7	4975	950	191	240	36	59 y	6.1	1000
Rwanda	5.4	2.9	263	45	170	190	29	61 y	6.2	1300
Senegal	8.5	4.4	356	45	127	570	22	45 y	5.8	1200
Sierra Leone	4.3	2.2	207	65	316	200	29	48	6.2	1800
Somalia	9.8	5.3	504	106	211	110	–	–	7.0	1600
South Africa	42.4	18.4	1280	84	66	3520	9	96	3.9	230
Tanzania	30.8	16.2	1281	184	144	170	27	48	5.6	770
Togo	4.2	2.2	179	22	125	300	19	85	6.2	640
Uganda	20.3	11.2	1040	147	141	300	26	64 y	7.1	1200
Zambia	8.3	4.6	356	72	202	360	24	75	5.6	940
Zimbabwe	11.4	5.8	436	35	80	610	16	91 y	4.8	570
MIDDLE EAST AND NORTH AFRICA										
Algeria	28.8	13.1	857	33	39	1520	13	95	4.0	160
Egypt	63.3	27.8	1690	132	78	1080	15	78 y	3.5	170
Iran	70.0	35.7	2446	91	37	1033	16	96 y	4.9	120
Iraq	20.6	10.1	770	94	122	1036	23	83 y	5.4	310
Israel	5.7	2.0	115	1	6	15870	–	–	2.8	7
Jordan	5.6	2.8	211	5	25	1650	9	89	5.3	150
Kuwait	1.7	0.8	40	1	14	17390	–	65	2.9	29
Lebanon	3.1	1.2	76	3	40	2970	3	–	2.9	300
Libya	5.6	2.9	227	14	61	5540	5	97	6.1	220
Morocco	27.0	11.5	714	53	74	1290	9	72	3.3	610
Oman	2.3	1.2	102	2	18	4820	23	71	7.2	190
Saudi Arabia	18.8	9.0	657	20	30	7040	–	62	6.0	130
Sudan	27.3	13.0	929	108	116	310	34	55 y	4.7	660
Syria	14.6	7.5	450	15	34	1160	13	97 y	4.2	180

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	Total population (millions) 1996	Population under 18 (millions) 1996	Annual no. of births (thousands) 1996	Annual no. of under-5 deaths (thousands) 1996	Under-5 mortality rate 1996	GNP per capita ($) 1996	% of under-5 children underweight 1987–97	Net primary school enrolment/ attendance [a] (%) 1987–97	Total fertility rate 1996	Maternal mortality rate [b] 1990
Tunisia	9.2	3.7	223	8	35	1930	9	97	3.0	170
Turkey	61.8	23.0	1371	64	47	2830	10	86 y	2.6	180
U. Arab Emirates	2.3	0.8	42	0	10	17400	14	83	3.6	26
Yemen	15.7	8.5	756	79	105	380	39	57 y	7.6	1400
CENTRAL ASIA										
Afghanistan	20.9	9.7	1127	290	257	250	–	24 y	6.9	1700
Armenia	3.6	1.2	50	2	30	630	–	–	1.8	50
Azerbaijan	7.6	2.8	154	7	44	480	10	–	2.4	22
Georgia	5.4	1.5	77	2	29	850	–	82	2.0	33
Kazakhstan	16.8	5.9	312	14	45	1350	8	–	2.4	80
Kyrgyzstan	4.5	1.9	117	6	50	550	–	86 y	3.3	110
Tajikistan	5.9	2.8	184	14	76	340	–	–	4.0	130
Turkmenistan	4.2	1.9	122	10	78	940	–	80 y	3.7	55
Uzbekistan	23.2	10.6	674	40	60	1010	19	95	3.6	55
EAST/SOUTH ASIA AND PACIFIC										
Australia	18.1	4.6	262	2	6	20090	–	98	1.9	9
Bangladesh	120.1	57.2	3186	357	112	260	56	76 y	3.2	850
Bhutan	1.8	0.9	76	10	127	390	38	41	5.9	1600
Cambodia	10.3	4.8	360	61	170	300	40	–	4.6	900
China	1232.1	378.0	20712	973	47	750	16	99	1.8	95
India	944.6	382.9	24381	2706	111	380	53	68 y	3.2	570
Indonesia	200.5	77.8	4732	336	71	1080	34	97	2.7	650
Japan	125.4	24.7	1281	8	6	40940	–	100	1.5	18
Korea, Dem.	22.5	7.0	493	15	30	970	–	–	2.1	70
Korea, Rep.	45.3	12.6	688	5	7	10610	–	93	1.7	130
Lao Rep.	5.0	2.6	227	29	128	400	40	69 y	6.7	650
Malaysia	20.6	8.9	539	7	13	4370	20	91	3.4	80
Mongolia	2.5	1.1	70	11	150	360	12	80	3.4	65
Myanmar	45.9	19.1	1276	191	150	220	43	85 y	3.4	580
Nepal	22.0	10.9	822	95	116	210	47	65 y	5.1	1500
New Zealand	3.6	1.0	56	0	7	15720	–	~100	2.1	25
Pakistan	140.0	68.3	5207	708	136	480	38	66 y	5.2	340
Papua New Guinea	4.4	2.0	144	16	112	1150	–	32 y	4.8	930
Philippines	69.3	30.9	2029	77	38	1160	30	89 y	3.7	280
Singapore	3.4	0.9	56	0	4	30550	–	100	1.8	10
Sri Lanka	18.1	6.4	322	6	19	740	38	–	2.1	140
Thailand	58.7	19.5	996	38	38	2960	26	–	1.8	200
Viet Nam	75.2	32.3	1975	87	44	290	45	81 y	3.1	160
AMERICAS										
Argentina	35.2	12.1	709	18	25	8380	–	95	2.7	100
Bolivia	7.6	3.6	258	26	102	830	8	89 y	4.5	650
Brazil	161.1	60.2	3211	148	46	4400	6	94 y	2.3	220
Canada	29.7	7.2	367	2	7	19020	–	95	1.6	6
Chile	14.4	5.0	294	4	13	4860	1	86	2.5	65
Colombia	36.4	14.6	878	27	31	2140	8	91 y	2.8	100
Costa Rica	3.5	1.4	86	1	15	2640	2	92	3.0	55
Cuba	11.0	2.9	149	1	9	1170	–	99	1.6	95
Dominican Rep.	8.0	3.3	198	11	56	1600	6	92 y	2.9	110
Ecuador	11.7	5.0	309	12	40	1500	17	92	3.2	150
El Salvador	5.8	2.6	166	7	40	1700	11	79	3.2	300
Guatemala	10.9	5.6	405	23	56	1470	27	58 y	5.0	200
Haiti	7.3	3.4	250	34	134	310	28	68 y	4.7	1000
Honduras	5.8	2.9	201	7	35	660	18	90	4.5	220

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These statistical profiles show the brutal disparities between countries.

Among these 192 nations, per capita GNP is as low as $80 and as high as $45,360 a year.

The under-5 mortality rate varies from 4 to 320 deaths per 1,000 live births.

The maternal death rate ranges from 0 to 1,800 deaths per 100,000 live births.

The primary school enrolment rate varies from 24% to 100% of young people.

***The Progress of Nations* seeks to put an end to these intolerable inequalities by exposing them to the conscience of the world community.**

	Total population (millions) 1996	Population under 18 (millions) 1996	Annual no. of births (thousands) 1996	Annual no. of under-5 deaths (thousands) 1996	Under-5 mortality rate 1996	GNP per capita ($) 1996	% of under-5 children under-weight 1987–97	Net primary school enrolment/ attendance a/ (%) 1987–97	Total fertility rate 1996	Maternal mortality rate b/ 1990
Jamaica	2.5	0.9	56	1	11	1600	10	100	2.5	120
Mexico	92.7	38.6	2351	75	32	3670	14	98	2.9	110
Nicaragua	4.2	2.1	145	8	57	380	12	83	4.0	160
Panama	2.7	1.0	62	1	20	3080	7	91	2.7	55
Paraguay	5.0	2.4	158	5	34	1850	4	89	4.3	160
Peru	23.9	10.1	615	36	58	2420	8	87 y	3.1	280
Trinidad/Tobago	1.3	0.5	21	0	17	3870	7	88	2.2	90
United States	269.4	70.4	3827	32	8	28020	1	96	2.0	12
Uruguay	3.2	0.9	54	1	22	5760	4	95	2.3	85
Venezuela	22.3	9.4	570	16	28	3020	5	88	3.1	120
EUROPE										
Albania	3.4	1.2	75	3	40	820	–	96	2.7	65
Austria	8.1	1.7	86	0	6	28110	–	100	1.4	10
Belarus	10.3	2.7	106	2	18	2070	–	95	1.5	37
Belgium	10.2	2.2	115	1	7	26440	–	98	1.6	10
Bosnia/Herzegovina	3.6	0.9	43	1	17	*	–	–	1.4	–
Bulgaria	8.5	1.9	86	2	19	1190	–	97	1.5	27
Croatia	4.5	1.0	48	1	11	3800	1	82	1.6	–
Czech Rep.	10.3	2.4	111	1	7	4740	1	98	1.5	15
Denmark	5.2	1.1	68	0	6	32100	–	99	1.8	9
Estonia	1.5	0.4	13	0	16	3080	–	94	1.4	41
Finland	5.1	1.2	62	0	4	23240	–	99	1.8	11
France	58.3	13.5	692	4	6	26270	–	99	1.7	15
Germany	81.9	15.8	774	4	6	28870	–	100	1.3	22
Greece	10.5	2.2	104	1	9	11460	–	91	1.4	10
Hungary	10.0	2.3	104	1	12	4340	2	93	1.5	30
Ireland	3.6	1.0	46	0	7	17110	–	100	1.9	10
Italy	57.2	10.5	528	4	7	19880	–	97	1.2	12
Latvia	2.5	0.6	25	1	20	2300	–	84	1.5	40
Lithuania	3.7	1.0	41	1	18	2280	–	–	1.6	36
Moldova, Rep.	4.4	1.4	61	2	32	590	–	–	1.9	60
Netherlands	15.6	3.4	190	1	6	25940	–	99	1.6	12
Norway	4.3	1.0	59	0	6	34510	–	99	1.9	6
Poland	38.6	10.6	463	6	14	3230	–	97	1.7	19
Portugal	9.8	2.1	110	1	7	10160	–	100	1.5	15
Romania	22.7	5.6	247	6	25	1600	6	92	1.4	130
Russian Fed.	148.1	37.1	1427	36	25	2410	3	100	1.4	75
Slovakia	5.3	1.5	64	1	11	3410	–	–	1.6	–
Slovenia	1.9	0.4	18	0	6	9240	–	100	1.3	13
Spain	39.7	8.2	387	2	5	14350	–	100	1.2	7
Sweden	8.8	2.0	108	0	4	25710	–	100	1.9	7
Switzerland	7.2	1.5	80	0	5	44350	–	100	1.5	6
TFYR Macedonia	2.2	0.6	32	1	30	990	–	85	2.0	–
Ukraine	51.6	12.4	511	12	24	1200	–	–	1.5	50
United Kingdom	58.1	13.3	706	5	7	19600	–	100	1.7	9
Yugoslavia	10.3	2.7	131	3	22	**	2	69	1.8	–

a/ Enrolment/attendance is derived from net primary school enrolment rates as reported by UNESCO and from national household survey reports of attendance at primary school.

b/ Several of the maternal mortality rates vary substantially from government estimates. A review of these data will be part of a forthcoming revision of maternal mortality estimates.

y/ School attendance data derived from household surveys.

* GNP per capita estimated range $785 or less.

** GNP per capita estimated range $9636 or more.

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LESS POPULOUS COUNTRIES

The indicators used to construct the league tables in *The Progress of Nations 1998* include: per cent of registered births; per cent of children *not* immunized against measles; and number of live births per 1,000 women age 15–19. Using the same indicators, the following table shows the progress of those countries with populations of less than 1 million. The regional standing of these less populous countries can be assessed by comparing the figures given here with the relevant league tables. In addition, basic social indicators, also provided in this table, can be compared with the Statistical Profiles on the preceding pages.

	League tables a/												
	Birth registration (category)	Measles immunization gap	Teen births	Total population (thousands) 1996	Population under 18 (thousands) 1996	Annual no. of births (thousands) 1996	Annual no. of under 5 deaths (thousands) 1996	Under 5 mortality rate 1996	GNP per capita ($) 1996	% of under 5 children underweight 1981–96	Net primary school enrolment (%) 1987–95	Total fertility rate 1996	Maternal mortality rate * 1990
Andorra	1	–	–	71	15	1	0.0	6	***	–	–	–	–
Antigua/Barbuda	1	0	–	66	23	1	0.0	22	7330	10	–	–	–
Bahamas	1	8	52	284	96	5	0.1	23	11940	–	95	2.0	100
Bahrain	–	5	22	570	207	12	0.3	22	7840	9	100	3.1	60
Barbados	1	0	51	261	72	3	0.0	12	6560	5	78	1.7	43
Belize	–	19	97	219	106	7	0.3	44	2700	–	99	3.8	–
Brunei Darussalam	–	0	24	300	118	6	0.1	11	25160	–	91	2.8	60
Cape Verde	–	34	78	396	190	12	0.9	73	1010	19	100	3.7	–
Comoros	–	52	130	632	336	26	3.2	122	450	26	53	5.7	950
Cook Islands	1	28	–	19	8	0	0.0	30	1550	–	–	–	–
Cyprus	–	10	30	756	226	12	0.1	10	10260	–	96	2.3	5
Djibouti	–	53	31	617	292	24	3.8	157	*	23	32	5.5	570
Dominica	1	0	–	71	25	2	0.0	20	3090	5	–	–	–
Equatorial Guinea	–	39	173	410	202	17	2.9	173	530	–	–	5.6	820
Fiji	1	6	48	797	326	18	0.4	24	2470	8	99	2.8	90
Grenada	1	15	–	92	33	2	0.1	31	2880	–	–	–	–
Guyana	1	9	57	838	315	19	1.6	83	690	18	90	2.4	–
Iceland	1	2	25	271	78	4	0.0	5	26580	–	–	2.2	0
Kiribati	1	36	–	80	37	2	0.2	76	920	13	99	–	–
Liechtenstein	1	–	–	31	7	0	0.0	7	***	–	–	–	–
Luxembourg	1	20	14	412	88	5	0.0	7	45360	–	85	1.7	0
Maldives	1	6	70	263	140	11	0.8	76	1080	39	60	6.8	–
Malta	1	49	13	369	98	5	0.1	11	7910	–	100	2.1	0
Marshall Islands	2	31	–	57	26	2	0.2	92	1890	–	100	–	–
Micronesia (Fed. States of)	2	10	–	126	58	4	0.1	27	2070	–	85	–	–
Monaco	1	2	–	32	7	0	0.0	6	***	–	–	–	–
Nauru	–	–	–	11	5	0	0.0	31	–	–	–	–	–
Niue	–	0	–	2	1	0	–	–	–	–	–	–	–
Palau	1	1	–	17	8	1	0.0	35	**	–	100	–	–
Qatar	–	14	66	558	175	10	0.2	21	11600	6	80	3.9	–
Saint Kitts and Nevis	1	0	–	41	15	1	0.0	38	5870	–	–	–	–
Saint Lucia	1	5	–	144	51	4	0.1	22	3500	–	90	–	–
Saint Vincent/Grenadines	1	0	–	113	40	2	0.1	23	2370	–	–	–	–
Samoa	–	4	34	166	75	4	0.2	53	1170	–	99	3.9	35
San Marino	1	4	–	25	5	0	0.0	13	–	–	–	–	–
Sao Tome/Principe	–	53	–	135	71	6	0.5	80	330	16	–	–	–
Seychelles	–	2	–	74	39	3	0.1	19	6850	6	–	–	–
Solomon Islands	1	33	94	391	199	14	0.4	29	900	21	–	5.1	–
Suriname	1	22	56	432	173	9	0.3	31	1000	–	100	2.5	–
Swaziland	–	41	85	881	439	33	3.2	97	1210	10	95	4.6	560
Tonga	–	5	–	98	41	2	0.1	23	1790	–	–	–	–
Tuvalu	1	6	–	10	4	0	0.0	56	650	–	98	–	–
Vanuatu	–	39	74	174	86	5	0.3	53	1290	20	74	4.5	280

a/ See appropriate chapter for full description.

b/ Several of the maternal mortality rates vary substantially from government estimates. A review of these data will be part of a forthcoming revision of maternal mortality estimates.

* GNP per capita estimated range $786 to $3115.
** GNP per capita estimated range $3116 to $9635.
*** GNP per capita estimated range $9636 or more.

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Age of data

The table below gives the average age of the latest internationally available data for three key indicators: the under-5 mortality rate, the net primary school enrolment/attendance rate and the percentage of under-5s who are underweight.

The more up-to-date statistics used by most governments and international organisations are often interpolated and/or extrapolated from past surveys. The table shows the number of years that have elapsed, on average, between the last national on-the-ground surveys and the year 1997.

In some cases, governments may have more recent statistics that have not yet been made available to the United Nations.

Average age of data (in years) on the three social indicators

SUB-SAHARAN AFRICA					
Benin	1.7	Gambia	3.0	Ethiopia	5.7
Senegal	1.7	Mozambique	3.0	Rwanda	5.7
Tanzania	1.7	Burkina Faso	3.7	Cameroon	6.7
Mali	2.0	Ghana	3.7	Botswana	7.0
Mauritania	2.0	Zimbabwe	3.7	Chad	7.3
Mauritius	2.0	Kenya	4.3	Sierra Leone	8.7
Zambia	2.0	Niger	4.3	Gabon	10.3
Malawi	2.3	Guinea	4.7	Liberia	10.3
Central African Rep.	2.7	Nigeria	4.7	Congo	13.3
Congo, Dem. Rep.	2.7	Togo	4.7	Guinea-Bissau	13.3
Eritrea	2.7	Lesotho	5.0	Angola	15.0
Madagascar	2.7	Namibia	5.0	Somalia	15.0
Uganda	2.7	South Africa	5.3		
Côte d'Ivoire	3.0	Burundi	5.7		
MIDDLE EAST and NORTH AFRICA					
Egypt	2.0	Turkey	3.3	Kuwait	6.0
Algeria	2.7	Yemen	3.3	Jordan	6.7
Iraq	2.7	Morocco	3.7	Libya	7.3
Oman	2.7	Sudan	4.0	Lebanon	8.3
Tunisia	3.0	Syria	4.0	Saudi Arabia	9.7
U. Arab Emirates	3.0	Iran	4.3	Israel	10.3
CENTRAL ASIA					
Uzbekistan	1.7	Kyrgyzstan	6.3	Afghanistan	10.0
Georgia	6.0	Azerbaijan	8.0	Armenia	11.0
Kazakhstan	6.3	Turkmenistan	8.3	Tajikistan	11.0
EAST/SOUTH ASIA and PACIFIC					
Bangladesh	1.3	Mongolia	4.0	China	8.0
Nepal	1.7	Philippines	4.0	Singapore	8.0
Australia	2.0*	Myanmar	4.3	Korea, Rep.	9.3
New Zealand	2.0*	Pakistan	4.3	Malaysia	10.0
Japan	2.5*	India	4.7	Cambodia	11.0
Lao Rep.	3.0	Bhutan	5.7	Thailand	11.7
Viet Nam	3.0	Papua New Guinea	6.0	Korea, Dem.	13.3
Indonesia	3.3	Sri Lanka	7.0		
AMERICAS					
Brazil	1.7	Uruguay	2.7	Paraguay	5.7
Dominican Rep.	1.7	Bolivia	3.0	Cuba	6.0
Peru	1.7	United States	3.0*	Mexico	6.0
Chile	2.3	Haiti	3.3	Jamaica	6.3
Costa Rica	2.3	Venezuela	3.7	Panama	7.0
Canada	2.5*	El Salvador	4.0	Ecuador	7.3
Colombia	2.7	Nicaragua	4.3	Argentina	7.7
Guatemala	2.7	Honduras	5.0	Trinidad/Tobago	8.0
EUROPE					
Latvia	1.5*	TFYR Macedonia	2.0*	United Kingdom	2.5*
Austria	2.0*	Croatia	2.5*	Belgium	3.0*
Belarus	2.0*	Estonia	2.5*	Russian Fed.	3.0*
Bulgaria	2.0*	Finland	2.5*	Norway	3.5*
Czech Rep.	2.0*	France	2.5*	Albania	4.0*
Denmark	2.0*	Germany	2.5*	Yugoslavia	4.5*
Hungary	2.0*	Greece	2.5*	Lithuania	8.0*
Poland	2.0*	Ireland	2.5*	Slovakia	8.0*
Romania	2.0*	Italy	2.5*	Moldova, Rep.	8.5*
Slovenia	2.0*	Netherlands	2.5*	Ukraine	9.5*
Spain	2.0*	Portugal	2.5*	Bosnia/Herzegovina	11.0*
Sweden	2.0*	Switzerland	2.5*		

* Underweight not included

Abbreviations

AIDS	acquired immune deficiency syndrome
BCG	anti-tuberculosis vaccine
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
DHS	Demographic and Health Surveys
DPT	combined diphtheria/pertussis (whooping cough)/tetanus vaccine
EU	European Union
GNP	gross national product
HIV	human immunodeficiency virus
ICRW	International Center for Research on Women
NGO	non-governmental organization
ODA	official development assistance
OECD	Organisation for Economic Co-operation and Development
ORS/ORT	oral rehydration salts/oral rehydration therapy
STD	sexually transmitted disease
TB	tuberculosis
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Throughout *The Progress of Nations*, a dash (–) signifies no data were available.

Note: All dollars are US dollars.

The Progress of Nations 1998 Production Team

Editorial staff

Catharine Way
Editor

Lisa Adelson
Angela Hawke
Richard Leonard
Kristin Moehlmann
John Richardson
Hashi Roberts
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Saudamini Siegrist

Statistical staff

Gareth Jones
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Mark Hereward
Nyein Nyein Lwin
Tessa Wardlaw
Khin Whit Yee

Administrative support

Barbara Chase
Fran Scott

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unicef

United Nations Children's Fund
Division of Communication
3 United Nations Plaza
New York, NY 10017, USA

E-mail: publish@unicef.org
Web site: www.unicef.org

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